# Psychopathology and Social Deviance Among Jews

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*. . . disparate studies do not reveal the "total national character" of the Jew. The fact is that the Jews do not constitute an homogeneous group. They belong to different social classes with different educations, origins and religious groupings. . . live in geographical areas ranging from the highly concentrated population in New York City to a small town in the Middle West and thus have different types of stresses impinging upon them and affecting their psychological adjustment.*

Seldom, if ever, in the long history of Jewry has there been a Jewish community as prosperous as that which exists today in the United States. The observer is frequently awed and sometimes dazzled by the complex fabric of American-Jewish life—the abundance of thriving national and local organizations, the participation of Jews, collectively and as individual citizens, in every aspect of American cultural, religious and charitable endeavor.

Yet, as one studies the structure of Jewish life in twentieth century America, one becomes increasingly aware that, notwithstanding its swift responsiveness to national and sectarian challenges, there is an area in which we, as a community, have yet to confront successfully one of our greatest challenges—the urgent and increasingly significant need for knowledge and understanding of American Jews.

The purpose of this paper is to review research on the psychopathology of the Jews. The small number of research studies specific to this topic is quite glaring in view of the large number of Jews in the helping professions.

This paper is divided into three parts. The first part will deal with the incidence in mental illness and will include information obtained from large epidemiological studies conducted in the 1950's and 1960's based on hospital admissions and surveys. The second will deal with reports obtained from clinical research with Jewish and non-Jewish populations, the third will deal with deviances such as alcoholism, drug abuse, and suicide. There is little information and research in these areas.

**A. Incidence and Surveys of Mental Illness Among Jews and Non-Jews**

This section refers to the well-known research conducted for the past few decades by Malzberg on the basis of admission rates to mental hospitals in New York State and Canada and also to Brenner's research which tried to relate the incidence of mental illness among various ethno-religious-nationality groups to economic changes. The latter part of this section includes comments on the rate of mental illness among Jews by Rinder, Armstrong and references to studies investigating the usage of psychiatric facilities by Jews. There are also references to the religious background and orientations of mental health practitioners.

Malzberg published a number of papers and books giving incidence figures of hospital admissions for mental disorders in the State of New York. He found[1a] the incidence for schizophrenia (new cases admitted in one year per 100,000 population) for various religious groups to be: Jews, 35.5 per 100,000; Protestants, 41.7 and Catholics, 41.2. The rate for Blacks

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[1] B. Malzberg, "The distribution of mental disease according to religious affiliation in New York State," 1949-1951, *Mental Hygiene,* 1962, 46: 510-522.

[1a] _____ *Mental disease among Jews in New York*, New York: International Medical Book Corporation, 1960.

was found to be 109 per 100,000[1b] and for Puerto Ricans, 99.4 per 100,000[1c].

Jews were also found to have low rates in psychoses of organic origin, alcoholism, psychoses and disorders of advanced age. On the other hand, they have higher rates for manic-depressive psychoses and psychoneuroses. Reasons accounting for such differences are difficult to analyze but an article by Sanua[2] discusses the problem of the interpretation of admission rates and points out that such rates need to be evaluated with caution.

Malzberg[3] analyzed the admission rates of Jews in Canada. Total admission rates for Jews and non-Jews were found to be 109.6 and 130.3 per 100,000 respectively. Malzberg believes that these figures were authentic. In Canada as a whole, however, Jews have more admissions for schizophrenia than non-Jews. Schizophrenia is more prevalent among urbanized groups, and Jews are highly urbanized in Canada. When limited to Ontario, where the degree of urbanization is approximately the same for all groups, the study showed no difference in the rates of schizophrenia between Jews and non-Jews. Higher rates for Jews occurred principally with respect to manic-depressive psychoses and psychoneuroses.

This writer feels that these differences in the rates of schizophrenia between Canada and the State of New York in relation to Jewish population may have a different interpretation. The lower rates of schizophrenia in New York may be explained by the high concentration of Jews in New York State. Approximately 40% of all Jews in the United States are concentrated in Greater New York. It was found that a larger concentration of ethnics might provide more community support and might tend to reduce hospitalization.[4] Canadian Jews might have been younger in age range and might have undergone faster acculturation than the Jews of New York State and are more dispersed than in New York. All these factors might have influenced the rate of schizophrenia.

A recent study has tried to relate the frequency of mental illness in various ethnic groups and employment rates in New York State hospital admissions. Brenner[5] found that the hospital population could be divided into four different groups with respect to employment rates. There was a high negative correlation between admissions and employment rates for Jews and German-Americans; thus they seemed to have been more negatively affected by the decline of the economy. The correlation was lowest for Blacks and Spanish-Americans and thus they were least affected by the variations of the economy. Brenner suggests that Jews in particular, as a group, experience "greater psycho-social loss" during periods of economic adversity because of their greater concern with socio-economic status as a reflection of their self-image. Blacks and Spanish-Americans are the lowest in the socio-economic status and seem to be least sensitive to changes in economic conditions.

However, admission rates represent what has been called the "tip of the iceberg,"

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[1b] _____ "Mental disease among Negroes: analysis of first admission in New York State, 1949-1951," *Mental Hygiene*, 1959, 43: 422-459.

[1c] _____ "Mental disease among Puerto Ricans in New York City, 1949-1951," *Journal of Nervous and Mental Disease*, 1956, 123: 262-269.

[2] V. Sanua, "The etiology and epidemiology of mental illness and problems of methodology," *Mental Hygiene*, 1963, 47: 607-621.

[3] B. Malzberg, "*The Mental Disease among Jews in Canada:* A study of First Admissions to Mental Hospitals, 1950-1952." Albany Research Foundation for Mental Hygiene, 1963.

[4] N.L. Mintz and D.T. Schwartz, "Urban ecology and psychosis: Community factors in the incidence of schizophrenia and manic depression among Italians of Greater Boston," *International Journal of Social Psychiatry.*

[5] Harvey Brenner, *Mental Illness and the economy*. Cambridge: Harvard University Press, 1973.

since they do not include patients seen by private practitioners and those who have never become a statistic in spite of their psychological disturbance.

During the early 1950's, two major epidemiological studies were conducted in New Haven and in New York. The New Haven study included patients treated under psychiatric sponsorship, while the New York study included treated and untreated patients seen by psychiatrists, psychologists and social workers.

Early in 1952, under the direction of Thomas Rennie and later under Alexander Leighton[6] an investigation was conducted in midtown Manhattan, a section of the city with a population of 170,000.

The following table shows the prevalence rates per 100,000 in the mid-town Manhattan census on the basis of religious background:

**Type of Hospital**

| Religious Group | Public | Private | Outpatient Clinics | Total |
|---|---|---|---|---|
| Jewish | 250 | 148 | 380 | 778 |
| Protestant | 385 | 61 | 103 | 549 |
| Catholic | 659 | 33 | 108 | 800 |

More non-Jews are admitted to state mental hospitals, yet more Jews are treated in private mental hospitals. The disparity between the two groups is greatest for outpatient with a ratio of 4 to 1, with more Jews being treated on an out-patient basis.

In this survey 1,660 persons were interviewed to obtain a mental health rating and the group was divided according to social class and religion. The following table lists the percentages of Jews and non-Jews among the untreated who were considered to have no symptoms and those who were considered impaired (p.305).

| Category | Protestant | Catholic | Jewish |
|---|---|---|---|
| Well | 20.2% | 17.4% | 14.5% |
| Impaired | 23.5% | 24.7% | 17.1% |

According to Scrole and Langner the very low percentage of very serious mental impairment among Jews is due to the following reasons:

> . . . mobilization of anxiety about the instability of the Jewish exilic environment may historically have been established as a conditioning pattern of the Jewish family structure. In one direction, such anxiety, subsequently magnified in the adult by extrafamily life conditions, may be reflected in our finding of an unusually large concentration of Midtown Jews in the sub-clinical mild category of symptom formation. On the other hand, this large component of historically realistic anxiety, as generated in the Jewish family, may function prophylactically to immunize its children against the potentially disabling sequelae of the more severe pressures and traumas of existence.[7]

The higher percentage of Jewish patients under private treatment would undoubtedly be affected by their readiness to seek psychiatric help. This fact was tested by Srole and Langner[8] who asked respondents an open-ended question posing certain psychiatric problems in a hypothetical family and inquiring about the most appropriate action to take. Jewish respondents, in comparison to the Protestant and Catholic groups, suggested far more frequently (49.2%) that seeing a psychotherapist was the most appropriate source. The percentages for the Catholic and Protestant groups were 23.8 and 31.4 respectively.

In the New Haven study, which included patients treated in clinics and privately, it was found that Jews[9] have the highest

[6] L. Srole, T.S. Langner, S.T. Michael, M.K. Opler, and T.A.C. Rennie (Eds.), *Mental Health in the Metropolis: The Midtown Manhattan Study,* Volume I. New York: McGraw Hill, 1962.

[7] L. Srole and T.S. Langner, "Religious origin" in L. Srole, *et al., Ibid* p. 306.

[8] *Ibid*

[9] B.H. Roberts and J.K. Myers, "Religion, National Origin, immigration and mental illness," *American Journal of Psychiatry,* 1954, 110: 759-64.

ambulatory treatment rates as compared to Protestants and Catholics and tended to have more cases of psychoneurosis and fewer cases of psychoses.

While Jews in general have more neuroses, they tend to be under-represented in disorders of organic origin such as advanced age, alcoholism and addictive disorders.

Weintraub and Aronson's[10] study of the characteristics of patients in classical psychoanalysis bears out the midtown Manhattan and New Haven finding about the over-usage of psychotherapy. Thirty analysts working in East Coast communities provided data on 144 patients. Forty percent of the patients were Jewish, 37% Protestants and 13% Catholics. Thus the sample included a disproportionate share of Jews and a gross under-representation of Catholics.

Rinder[11] contended that if the Jewish family patterns continue to prevail, such as that of upward mobility, the overall impairment rate will remain below average. However, if catastrophe, such as economic collapse or racial and religious hostility should erupt and be directed against Jews, could these patterns be reversed? The rate of neurosis would decrease and the rate of psychosis would increase. Armstrong[12] believes that acculturation and not ethnicity is the determinant in the rates of mental illness among Jews.

**B. Clinical Research—Symptomatology and attitudes towards mental illness among Jews and non-Jews.**

This section is a review of research on Jewish and non-Jewish mental patients in different clinical settings. Investigators were primarily interested in differences in symptoms shown by the two groups.

In 1945, Adler[13] wrote that she was unaware of any comprehensive study examining the influence of different economic levels upon the development and the prognosis of neuroses and behavior problems among children. The same statement could be made in 1981.

She reported that while Jewish children have eating difficulties and little enuresis, Italian children have no eating difficulties but suffer quite frequently from enuresis.

Among Italian children the incidence of overt aggressive behavior difficulties and untidiness was rather high. Neglect and harsh treatment by parents were also significant among this group. On the other hand, parent indulgence in both Italian and Jewish groups exceeded that in the group of British descent. Also distinctive for the Jewish group were the seclusion of the children, maternal overprotection, immaturity, and nagging mothers. The children of British descent tended to be unwanted, to come from broken homes, and to have an excessive number of nervous habits.

Barrabee and Von Mering[14] conducted a study at the Massachusetts Mental Health Center in Boston with 69 psychotic patients (diagnosis unspecified) ranging in age from 18 to 35, males and females of Protestant, Jewish, Irish and Italian extraction. The findings regarding the "Yankee" and Jewish families revealed the following:

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[10] W. Weintraub and H.A. Aronson, "Survey of patients in classical psychoanalysis. Some vital statistics," *Journal of Nervous and Mental Disease,* 1968, 98-102.

[11] I.D. Rinder, "Mental health of American Jewish urbanites: A review of the literature and predictions," *International Journal of Social Psychiatry,* 1963, 9: 104-109.

[12] Renata G. Armstrong, "Mental Illness Among American Jews," *Jewish Social Studies,* 1965, 27: 1-3-11.

[13] Alexandra Adler, "Influence of the social level on psychiatric symptomatology of childhood difficulties," In *Sociological Foundations of the Psychiatric Disorders of Childhood.* Proceedings of the 12th Institute of the Child Research Clinic, of the Woods School with the collaboration of the School of Medicine of Duke University, N.C., 1945.

[14] P. Barrabee and O. Von Mering, "Ethnic Variations in Mental Stress in Families with Psychotic Children," *Social Problems,* 1953, 1: 48-53.

In the white Protestant family there is positive affection, yet a pronounced tendency not to display it. There is competition for parental affections between siblings in such families. The child is satisfied with indirect signs of love rather than with more direct evidence of love. The white Protestant mother may withdraw love. This control differs from that of the Jewish mother because the Protestant mother emphasizes the moral implications of transgressions rather than their impact on her own well-being, thus seeming to give the son a high degree of guilt and a strong sense of inadequacy. The white Protestant father is not a dominant and applies little physical punishment.

The mother-son relationship in the Jewish family is highly emotional, overprotective and overtly affectionate. The withdrawal of love, the technique preferred by the Jewish mother, engenders in the son a feeling of inconsistency in regard to the mother's affection and results in ambivalent feelings. Thus, while the child has an exaggerated dependency on the mother, he seems to have a deep-rooted hostility towards her (as reflected by some Jewish novelists writing about their mothers). The Jewish father yields much of the control of the home to his wife and does not punish the child. The son is not likely to have strong negative feelings about the father, but neither is he willing to accept him as a role model.

The foregoing clinical reports may reflect the attitudes and behavior of Jewish parents who were probably born in Europe, but do these parent-child interactions persist with acculturation to the American ethos? In a study dealing specifically with this problem Wolfenstein[15] at the Child Guidance Institute of the Jewish Board of Guardians in New York City compared Jewish mothers born abroad in Russia and Poland with United States native-born Jewish mothers, and their interactions with their offspring. The Eastern European mothers saw the child at any age as extremely vulnerable and incapable of taking care of himself. At the same time the child appeared to be showing independence and to be capable of "killing the mother." She was a suffering mother deriving emotional gratification in a narcissistic way. The American Jewish mother as described, saw the child not as fragile but mainly as an independent being who should stop being babied as quickly as possible and proceed to acquire skills.

Segal and Yahraes[16] in a book entitled *A Child's Journey: Forces that Shape the Lives of Our Young,* made a strong defense of the "Jewish" and "Italian" mothers celebrated by comedians and writers. Their observations on the raising of children today led them to comment:

> The Jewish mother surely produced a few ripe candidates for therapy, but she did not nurture a cohort of angry criminals or flat, schizoid personalities, empty shells incapable of recognizing or giving love. Whatever tendencies Jewish mothers and fathers have to be "superprotective" and whatever they may do in creating unusual anxieties in their children, the child mental health authority, Selma Fraiberg, says, "There are worst diseases of moral conflict, which are after all curable. In contrast, there is nothing one can do to overcome the disease of non-attachment created when there is no bond to begin with" (p.102).

Moreover, as Fraiberg reminds us, "neurotic" reaction to the overprotective mother can often lead to some very successful adaptations. Among the products of her commitment and caring are not only the couch-ridden Portnoys but the Leonard Bernsteins and John F. Kennedys of the world. She has produced the builders and

[15] M. Wolfenstein, "Two types of Jewish mothers," M. Mead and M. Wolfenstein, (eds.), *Childhood in Contemporary Cultures.* Chicago: University of Chicago Press, 1955.

[16] Julius Segal and Herbert Yahraes, *A Child's Journey, Forces that shape the Lives of Our Young,* New York: McGraw-Hill, 1978.

leaders of civilization, not the assassins and destroyers (p. 103).

Segal and Yahraes quote Bronfenbrenner's observations that the middle class today is approaching the level of social disorganization that characterized the low-income family in the early 1960's, and Margaret Mead's statement that this is "a society of people who neglect our children, are afraid of our children, find children a surplus instead of a raison d'etre of living."[17]

Fernando[18] comparing Jewish and Protestant depressed patients with normal controls in England, strengthened the marginality hypothesis. Paternal inadequacy and the weakening of ethnic ties and religious influence were related to depression among Jews but not among Protestants.

Bart[19] found the rate of depression to be unusually high among middle-aged Jewish women in comparison to their black and white non-Jewish counterparts. She traced this disproportion to the unusually strong emotional tie between mother and children, especially sons, in the Jewish family. Depression occurs following the loss of this maternal role. Non-Jewish women exhibiting this "typical Jewish pattern" in relating to their children were found to be equally vulnerable to depression.

Breen[20] found that there was a higher incidence of paranoid schizophrenia among the blacks while Jewish schizophrenics tended to be hebephrenic, catatonic or simple. He suggested that the basic cultural values between the two groups would account for these differences. Children in black families receive harsher treatment; there is a free expression of aggression; and they continue to fear asault as they grow older. On the other hand, in Jewish families the emphasis is on strong family ties, the withholding of aggressive expression, and the development of dependency. When carried to an extreme, these tendencies result in the different types of schizophrenia mentioned above. Figelman[21] following Breen's study of the withholding of aggression, hypothesized that the internalization of anger among Jews would increase the incidence of affective disorders. He confirmed his hypothesis by studying two groups of acutely schizophrenic, hospitalized blacks and Jews in the same state mental institution. There was a high incidence of depression among Jews and a high incidence of paranoid schizophrenia among blacks.

While Figelman realized that the Jewish patients tended to belong to a higher socioeconomic class, he felt that a Jewish patient in a state hospital would be of lower socioeconomic status than the Jewish population in general.

Sanua[22] formulated the hypothesis that there are socio-cultural components in the reactions of Jewish patients to stressful situations and disabilities. He compared the reactions of Jewish, "Old American," Irish American and black amputees to the loss of a limb. A major difference was that the Jewish patient was more likely to cry and express deep mourning at the loss of a limb than a non-Jewish patient because Jewish families permit overt expression of affect.

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[17] *Ibid,* p. 103.

[18] S.J.M. Fernando, "A cross-cultural study of some familial and social factors in depressive illness," *British Journal of Psychiatry,* 1975, 127: 46-53.

[19] Pauline Bernice Bart, "Depression in middle-aged women: Some socio-cultural factors." *Dissertation Abstracts,* 28B, 4752. Los Angeles: University of Californi, 1968.

[20] B. Breen, "Culture and Schizophrenia: A study of Negro and Jewish schizophrenics," *International Journal of Social Psychiatry,* 1968, 14: 282-289.

[21] M. Figelman, "A comparison of affective and paranoid disorders in Negroes and Jews," *International Journal of Social Psychiatry,* 1968, 14: 277-281.

[22] V. Sanua, "Sociocultural factors in responses of stressful life situations: Aged amputees as example," *Journal of Health and Human Behavior,* 1960, 1: 17-24.

Zborowski[23] reported on an earlier study that Jewish families and patients were often more concerned with the etiological and prognostic implications of pain and often refused pain-killing drugs, as they were more interested in a cure than a reduction of pain. Italian patients were more concerned with alleviation of the symptom. In the case of mental illness Jewish and Irish relatives seemed to react differently to the symptoms of the patient in their family, a fact that seems to support previous studies. According to Wylan and Mintz[24], significantly more Irish than Jewish families tolerated *deviant thinking* in a psychotic relative, while significantly more Jewish families than Irish families tolerated *deviant verbal emotionality*. Thus, it would seem that among Jews, the tendency is to overemphasize correct thought and proper intellect and communication.

One of the controversial areas in the studies of psychotic children is the diagnostic categories that were introduced in the early 1940's and 1950's. Bender[25] used the label childhood schizophrenia; Kanner[26] introduced a new concept, *infantile autism;* and Mahler[27] referred to such children as *symbiotic*. It is interesting to note that Bender remarked that she has hardly seen autistic children at Bellevue, and Mahler developed her own ideas primarily in studying a small number of patients in Austria and New York, mostly private patients. Perhaps these differences were due to the fact that all of them were dealing with different populations. Bender most likely had children of immigrant groups; Kanner's cases were more likely from parents born in the United States; and Mahler would have tended to have Jewish patients in her private practice. Infantile autism may be a rare illness among Jewish newcomers to the United States, while such cases may exist in acculturated Jewish families. The symbiotic child may be found more frequently among Jews because of the strong mother-child relationships that are usually found in these families. Two of Sanua's papers[28, 29] have dealt with this sociocultural aspect of infantile autism and childhood schizophrenia.

In 1963, Sanua compared the families of Jewish and Protestant schizophrenics. There was more pathology among Jewish mothers than among Jewish fathers of the lower class.[30] In the Protestant families the fathers were subject to more pathological disturbance than the mothers and found that more of the siblings of Jewish schizophrenics were themselves seriously disturbed as compared to the siblings of Protestant families. The divorce rate among Jews was about ten percent while it was fifty per cent for the Protestant group. The rate of divorce for Jews may be higher today since we dealt with a sample of adult schizophrenia in the sixties.

The next set of studies was conducted

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23 M. Zborowski, "Cultural components in response to pain, *Journal of Social Issues,* 1952, 8: 16-30.

24 Wylan, L. and N. Minta, "Ethnic differences in family attitudes towards psychotic manifestations, with implications for treatment programmes," *International Journal of Social Psychiatry,* 1976, 22: 86-95.

25 Lauretta Bender, "Childhood Schizophrenia," *Nervous Child,* 1941-42, 1: 138-140.

26 L. Kanner, "Autistic disturbances of affective contact," *Nervous Child,* 1943, 2:217-250.

27 M. Mahler, "On Child psychosis and schizophrenia: Autistic and symbiotic infantile psychosis," *Psychoanalytic Study of the Child,* 1952, 7: 286-305.

28 V. Sanua, "Childhood schizophrenia and infantile autism: a critical review of the issues from the sociocultural point of view." Presented at the International Congress of Child Psychology, Paris, July 1-8, 1979.

29 _____ "Cultural changes and psychopathology in children." Keynote adress to World Federation for Mental Health Convention, Salzburg, Austria, July 8-13, 1979.

30 _____ "The Sociocultural Aspects of Protestant and Jewish Schizophrenics," *International Journal of Social Psychiatry,* London, 1963, 9: 27-31.

abroad. Grewel[31] found differences in symptomatology between Ashkenazi Jews of German-Polish origin and Sephardi Jews of Spanish-Portugese origin in the Netherlands. Ashkenazi patients tended to be vivacious, extroverted, and versatile, while Sephardi Jews were described as quiet, restrained, and often dignified in behavior. Dutch Ashkenazi Jews in particular exhibited a high percentage of manic-depressive psychoses, and it was twice as high among the women (21%) as among the men (9%). On the average, 11% of the Sephardi patients were depressed. They tended to have more schizothymic characteristics.

In Israel, Goldman[32], likewise found differences between Ashkenazim and Sephardim. The former showed a broader grouping of symptoms indicating mood disorders, while the latter tended to show more limited groupings of more acute symptoms indicating schizophrenic disorders. A recent study by Gershon[33] in Israel likewise found that the Ashkenazi patient in Jerusalem tended to have more affective disorders than the non-Ashkenazi.

Ramon,[34] in Israel, conducted some rather sophisticated exploratory research on the antecedents of schizophrenia. While the dominant culture in the country is Western-oriented, about half of the population is of Middle Eastern ancestry.

Ramon believed that cultural change could influence a family caught in this social process to the extent that one of its offspring could exhibit schizophrenic behavior. The merit of the study was that she took into consideration communication within the family and its cultural background. Ramon hypothesized that families experiencing serious problems of acculturation would show fewer psychological disturbances as a whole, although one of the members might manifest schizophrenia. In the absence of abrupt cultural change Ramon predicted the development of schizophrenia on the basis of disturbed communi-cation within the family. Four types of families were included in the study: two triads of twenty Polish and Yemenite families with a schizophrenic child and two control groups consisting of Polish and Yemenite families with a child who had suffered from polio, i.e., a total of forty families. Ramon administered the Thematic Apperception Test cards, and (on the basis of the analysis of the stories) she confirmed the hypothesis that the families of schizophrenics, expected to score higher on the cultural deviance scale (the Yemenites), would be lower in defects in communication than the comparable group (the Poles). Ramon concluded that the treatment of a Yemenite family should be directed at clarifying conflicts in values rather than the intrapsychic conflicts of the schizophrenic family member. Their chances of recovery would be better than that of the schizophrenics of the Polish sample, since the latter showed a higher degree of psychopathology in communication than the Yemenite sample.

Systematic studies of Jews in Europe do not seem to exist. However, a Swiss psychiatrist, Levi[35] noted that an analysis of 1000 psychiatric patients admitted to a private Swiss clinic who were psychotic re-

[31] F. Grewel, "Psychiatric differences in Ashkenazim and Sephardim," *Psychiatria, Neurolgia, Neurochirugia,* 1967, 70: 339-347.

[32] I.M. Goldman, "Psychopathology of European and Afro-Asian Jews," *Dissertaion Abstracts,* 32 (6B) 3634-3635. New Brunswick, Rutgers University, 1971.

[33] Elliot S. Gershon and Jerome H. Liebowitz, "Sociocultural and demographic correlates of affective disorders in Jerusalem," *Journal of Psychiatric Research,* 1975, 12: 37-50.

[34] Shulamit Ramon, "The impact of culture change on schizophrenia in Israel," *Journal of Cross-Cultural Psychology,* 1972, 3: 382-382.

[35] Von R. Levi, "Ein Beitrag zur Klinik der atypischen psychosen." Sonderabdruck aus der Schweizerischen Medizinischen Wochenschrift 83, Jahrang 1953. Beiheft zu Nr. 38 Seite 1533, 1-21.

vealed 31 cases considered as "atypical" on the basis of unusual symptomatology and development of the illness. He found that 57% of the cases were Jewish, although the Jewish patients made up only 16% of the total caseload. Levi suggested this could be explained on the basis of the peculiar environmental background of Jews as a minority group.

The above findings which were conducted at different periods of Jewish acculturation in the United States reveal that Jewish children tended to have eating problems, and tended to have more dominating mothers. Jews were less interested in alleviating symptoms and more concerned in finding cures. They tended to be more depressed and less likely to be aggressive and paranoid in their illnesses. It is interesting to note that despite the fact of their minority status, Jews do not seem to select projection as a defense mechanism but tend to internalize their anger. Different findings among psychotic children may have been a function of the background of these children. Ashkenazi patients tend to be more depressed than Sephardi patients. However, in view of the limitations of such studies dealing with different populations at different times, these findings need further corroboration before they can be accepted as scientific facts.

### Psychological and Social Deviances Among Jews

This is the least well documented information on Jews. I shall refer to such deviancies as alcoholism, drug addiction, suicide, homeless Jewish men, and homicide.

Snyder[36] states that Jews internalize ideas of sobriety as a virtue and bring to the drinking situation powerful moral sentiments and anxieties which prevent intoxication. Furthermore, Orthodox mores, which circumscribe the social life of the observant Jews, tend to control the influence of the out-group on drinking behavior. However, Snyder maintains that when the insulating function of Judaism disintegrates, moderate drinking would give way to what he calls convivial and hedonistic drinking.[37]

Glatt[38] found that during a period of 10-15 years in London, the proportion of Jewish alchoholics was not as low as initially expected. He found that the common denominator among Jewish alcoholics and drug addicts was alienation from their Judaism and family, leaving them without their former anchorage. A national survey on drinking by Cahalan[39] found that drinking was not a problem for the majority of the Jewish respondents.

Rosenbloom,[40] in a study of Jewish drug addicts resident in the U.S. Public Health Service Hospital in Lexington, Kentucky, found that out of 32 Jewish patients, 70 percent were the youngest or the only child in the family. Generally, the role of the father was weak, and frequently a father figure was lacking entirely or for a crucial period of time. Ninety percent came from New York City. The social climate of New York City certainly accounts for this high percentage of Jewish drug addicts from that city.

Schmidt and Popham[41] found that while Jews constitute six percent of the adult population of Toronto, they contributed

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[36] C.R. Snyder, "Inebriety, alcoholism and anomia" in M.B. Clinard (ed.), *Anomia and Deviant Behavior*, New York: Free Press, 1964: 189-212.

[37] J.H. Skolnick, had similar findings: "Religious affiliation and drinking behavior," *Quarterly Journal of Alcoholism*, (1957-1958), 21: 548-551.

[38] Max M. Glatt, "Jewish alcoholics and addicts in the London area," *Mental Health and Society*, 1975, 2: 168-174.

[39] D. Calahan, *Problem Drinkers: A National Survey*. San Francisco: Jossey Bass, 1970.

[40] J.R. Rosenbloom, "Notes on Jewish drug addicts," *Psychological Reports*, 1959, 5: 769-772.

[41] Wolfgang Schmidt and Robert E. Popham, "Impressions on Jewish alcoholics," *Journal of Studies on Alcohol*, 1976, 37: 931-939.

0.5% of all admissions to one private and one public clinic for alcoholism. The researchers had to go through 6000 case records to find twenty-nine cases of alcoholism among Jews during a period of ten years. Again, as in the case of Glatt's study, more than half of the subjects were removed from Jewish culture and tended to be small business proprietors. It was also found that a high degree of instability would have to be present for a Jew to become an excessive drinker. They exhibited three types of denial: denial of alcoholism, denial of "Jewishness" and denial of the notion of Jewish sobriety. The Orthodox Jews tended to deny the existence of alcoholism and believed that they were being treated for physical ailments. Those who had little attachment to Judaism denied their Jewish affiliation and thus experienced less dissonance in their thinking about Jewish sobriety. Those Jews who admitted their alcoholism and their Jewishness denied the existence of Jewish sobriety.

There has been some discussion lately about the increase of drinking problems among the Jews. It would seem, according to Zimberg[42] that the treatment of alcoholism in Jews may be difficult because of the severe stigma attached to alcoholism. He feels that the staff of social agencies and rabbis should know about alcoholism and open their doors to Alcoholics Anonymous meetings with the hope that it may lessen the stigma and help Jews who develop drinking problems to go for treatment early in the course of their illness.

It would seem that since Durkheim[43] dealt with the suicide rate among Jews, nothing comparable has appeared in the literature, and his statistics are still referred to today. Durkheim noted that Jews have a low rate of suicide compared to non-Jews. He added that the fear of punishment after death should not be considered as a variable affecting the rate of suicide. While Protestants fear the hereafter, their rates are higher than the Jewish rate in spite of the fact that belief in immortality among Jews plays a very limited role in their faith. What seems to prevent suicide is a family sentiment which remains quite strong among Jews. However, Durkheim points out that during the latter part of the nineteenth century in Bavaria, where Jews tended to be highly assimilated, their rate of suicide was equal to that of the Protestants. Prinzing[44] pointed out that suicide was related to drinking. Since Jews do not drink, suicide is rare. Women commit suicide less frequently perhaps because they drink less. It is to be noted that Snyder[45] indicated that group solidarity seems to be an important factor in low rates of alcoholism. Thus, it would appear that suicide, alcoholism and group solidarity seem to be interrelated. McClelland[46] and his group of investigators have added another dimension to alcoholism. They pointed out that Irish, Finnish, and Jewish mothers are overprotective, but the key difference among these groups is that in the first two cultures the boys have to prove that they are "men." A Jewish boy always knows that he is a "man" and he is constantly reminded of it by his mother and by certain ritual observances such as the Bar Mitzvah.

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[42] S. Zimberg, "Sociopsychiatric perspectives on Jewish alcohol abuse: implications for the prevention of alcoholism," *American Journal of Drug and Alcohol Abuse,* 1977, 4: 571-579.

[43] E. Durkheim, *Suicide,* London: Routledge, Kegan, 1952.

[44] Prinzing, Trunksucht und selbstmord und deren gegenseitlge Beziehungen Leipzig, J.C. Hinnich'che Buchhandlung, 1895.

[45] C.R. Snyder, *op.cit,* 189-212.

[46] D. McClelland, C. Davis, W.N. Koln and E. Wanner, *The Drinking Man.* New York: The Free Press, 1972.

Landau[47,48] compared three groups of homicide offenders in Israel—Western Jews, Oriental Jews and non-Jews (mostly Arabs) as to type of offense and previous known disturbance. There were altogether 279 offenders selected from 1950 to 1964. It was found that the relative representation of non-Jews among homicide offenders was more than six times the corresponding representation of Jews. The representation of Oriental Jews was almost twice that of Western Jews. Landau found that the Western Jews registered the lowest as regards outward-directed personal violence (30%) and the highest as regards inward-directed violence, suicide and homicide-suicide cases (27%). This group also exhibited the highest proportion of insanity and physical and mental problems prior to the homicide. Non-Jews registered the highest in acting-out violent behavior (51%) but registered low on suicide and homicide (1.7%). This group manifested the lowest proportion of insanity and physical and mental problems prior to the homicides. Oriental Jews were located between these two extremes. However, the characteristics of this group are generally closer to those of Western Jews than non-Jews. The higher rate of homicide for the Oriental Jews might be due to their immigration to the Western-oriented Israeli culture with all the difficulties of making the transition. Landau explains her findings on the Arabs on the basis of cultural tradition, violence in many cases being a social norm or even culturally prescribed behavior. It is also possible that Oriental Jews were still influenced by these norms of behavior. It is to be noted that this study was conducted in Israel during a period characterized by many upheavals and therefore should not be generalized to other Jewish populations.

Levinson[49] found that the "Bowery Jews", who are far removed from Jewish cultural norms were far worse off psychologically than their non-Jewish counterparts, as was the case with homicidal Jews. It is interesting to note that the Jewish homeless men scored decidedly higher in verbal ability than in the performance part of the I.Q. test, a finding which is general to Jews.

The general conclusion that can be drawn from these studies is that family solidarity and identification with one's group appear to reduce the incidence of alcoholism, drug addiction, suicide. Other drastic tendencies like crime for the Jews seem to indicate serious psychiatric disturbance.

## Conclusion

Kraepelin,[50] well known for his work on the classification of mental illness, visited mental institutions around the world and pioneered in reporting the effects of culture on mental illness. He indicated that an exploration of the psychiatric features of a nation could foster an understanding of the total national character. Kraepelin embarked upon the study of foreign cultures after becoming aware of the relationship between the increase in the incidence of mental disease and the development of industrialization. Kraepelin's interest in comparative psychopathology was also strengthened by his belief that European Jews manifested patterns of mental illness

[47] Simha Landau, "Type of homicide and pathologies among homicide offenders. Some cultural profile in M. Riedel and T.P. Thornberry, (eds.), *Crime and delinquency: Dimension of Deviance,* New York: Praeger, 1974.

[48] Simha Landau, "Pathologies among homicide offenders: Some cultural profiles," *British Journal of Criminology,* 1975, 15: 157-166.

[49] B. Levinson, "The socioeconomic status, intelligence and personality traits of Jewish homeless men, *Yivo Annual.* Jewish Social Science, 1956-57, 11: 122-141.

[50] E. Kraepelin, "Vergleichende Psychiatrie" ("Comparative Psychiatry"), *Zentralblatt fur Nervenheilkunde und Psychiatrie,* 1904, 15: 433-437. Also to be found in English in *Transcultural Psychiatric Research,* Review and Newsletter, April, 1965, 11: 9-12.

different from those of other Europeans. A Swiss psychiatrist, Levi[51] reached the same conclusions many years later. However, Kraepelin never recorded his observations systematically.

Except for the fact that Jews seem to have more neuroses and less psychoses than non-Jews, the present review of the research is somewhat limited, as the cited disparate studies do not reveal the "total national character" of the Jew. The fact is that the Jews do not constitute an homogeneous group. They belong to different social classes with different educations, origins, and religious groupings (Orthodox, Conservative, Reform, and so on). Furthermore, Jews live in geographical areas ranging from the highly concentrated New York City to a small town in the Middle West and thus have different types of stresses impinging upon them and affecting their psychological adjustment. The importance of these variables was demonstrated by Sanua[52] in his controlled study of adolescents where he found that the third generation adolescent Jewish male and female showed more anxiety on psychological testing than the first and second. In future studies such variables should be taken into serious consideration.

Thus all we have are isolated studies with different approaches. In conclusion there is a crying need for American Jewry to develop the research instrumentality worthy of its reputation. It is hoped that a Jewish foundation would be willing to provide substantial funds to be used for this badly needed research on Jews.

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[51] Von R. Levi, *op. cit.*

[52] V. Sanua, "Differences in Personality Adjustment among Different Generations of American Jews and Non-Jews," M.V. Opler, (ed.), *Culture and Mental Health,* New York, Chapter 20, 1959, 443-466.