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Anthropology, Expressed Emotion, and Schizophrenia

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The question of how social response[1] to schizophrenic illness[2] varies across cultures has long been of interest to anthropologists (Corin 1990; Edgerton 1966; Estroff 1981; Janzen 1978; Jenkins 1988a; Kennedy 1974; Murphy 1976; Scheper-Hughes 1979; Townsend 1978; Wallace 1961; Waxler 1974). A principal issue is whether social responses are mediated primarily by culture *or* by the severity of individual psychopathology. In support of the latter position, Murphy (1982:70) has argued that

> there seems to be little that is distinctively cultural in the attitudes and actions directed toward the mentally ill. . . . There is apparently a common range of possible responses to the mentally ill person, and the portion of the range brought to bear regarding a particular person is determined more by the nature of his or her behavior than by a preexisting cultural set to respond in a uniform way to whatever is labelled mental illness.

Murphy argues for a universalist perspective that is independent of culture and dependent upon presumably invariant response to de-

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viant behavior. Counter to Murphy's claim, other evidence argues for the relevance of factors ranging from culturally variant kin constructions of the nature of the problem (Jenkins 1988b), to divergence among cultural traditions within psychiatry (Townsend 1978), to local variations of political economy (Warner 1985).

The most pressing reason to attend to this problem is the implication of sociocultural factors in the cross-cultural variability in course and outcome of schizophrenia (Murphy and Raman 1971; Waxler 1977). Better outcomes, in the forms of relatively less psychotic symptomatology and greater social functioning, have been observed in non-Western nations, such as Nigeria and India (World Health Organization [WHO] 1979).[3] Since neurophysiological, psychopharmacological, and natural history of disease explanations are insufficient to explain these findings (Sartorius, Jablensky, and Shapiro 1978), it is essential to examine psychocultural factors that may make a difference in illness trajectories. In this paper I examine dimensions of social response that may be not only cross-culturally variable, but relevant to variations in patterns of recovery from mental disorder.

EMOTION AS AN INTERACTIVE ATMOSPHERE

My strategy for addressing this issue requires reviving a tradition of interest in schizophrenia dormant in psychological anthropology in recent years. This tradition in psychological anthropology is that of regarding mental disorder, and schizophrenia in particular, as an interactive process rather than as a discrete disease entity. Its approach was established in the collaboration between Harry Stack Sullivan and Edward Sapir, who together considered schizophrenia as a paradigmatic case for the analysis of fundamental human processes (Sapir 1961; Sullivan 1962). The anthropological contribution was Sapir's well-known identification of the locus of culture in the interaction of specific individuals and the meanings that they abstracted for themselves from those interactions (1961:151). From the psychiatric side, Sullivan's contribution was an understanding of mental disorder as any interpersonal process inadequate to a particular situation, tracing a continuum from everyday momentary slips of memory to psychotic fixed delusions (1953:283).

For Sullivan, this notion was integrally connected with an understanding of the self-system as a configuration of interpersonal de-

vices for protection against emotional distress and for seeking emotional comfort (Chapman 1976:95), thereby highlighting the importance of emotional atmospheres reciprocally created in the interpersonal space of related selves (Sullivan 1962). Sullivan and Sapir agreed that a person with a psychiatric disorder must be evaluated in the context of his or her general interpersonal and social situation, with particular attention to the emotional atmosphere. Unfortunately, the collaborative program for the study of schizophrenia never reached fruition (Perry 1982) and has not reached its potential in psychological anthropology (Kennedy 1974:1120).

The work of Bateson is equally a pillar of this tradition, for his influential concept of the double bind focused on the reciprocal construction of interactive settings, offering a powerful hypothesis about the perception and consequences of disordered communication within family settings (Bateson, Jackson, Haley, and Weakland 1956; Bateson 1960a, 1960b, 1972, 1979). For a variety of reasons, the popularity of Bateson's approach has declined along with that of other approaches to the family environment as "schizophrenogenic."[4] Here, however, I would draw attention, instead, to the curious lack of connection between Bateson's work on schizophrenia and his work on emotional atmosphere encapsulated in the concept of ethos (1958). To roughly summarize the contrast between the two concepts, ethos refers to the emotional environment of a whole culture, whereas the double bind refers to the communicative environment of a family. Ethos has a more explicitly affective slant, while the notion of communication underlying the double bind concept leans toward the cognitive. The former concept, developed in a tribal context, is descriptive and contributes more obviously to a theory of culture, while the latter, developed in our own society, is causal and is addressed to clinical practice. It is unfortunate that Bateson never explicitly integrated the two lines of thought to examine modifications of cultural ethos within the emotional atmosphere of families afflicted with mental disorder. That this integration could be achieved is evident when we observe that the notion of ethos itself was elaborated with examples of closely interactive data (Bateson 1958:119–120), such that the ethos of a culture can be understood as abstracted from characteristic emotional atmospheres of discrete interpersonal situations. Yet, like Bateson, subsequent researchers have not made the synthesis, and the conse-

quence has been a disciplinary segregation of his ideas: while anthropologists thought about ethos, psychiatrists and psychologists thought about the double bind.

As a result of these developments, anthropology has been left without a rigorous way to describe and examine the emotional atmospheres that exist among the self-systems of any interpersonal situation, let alone those critical situations involving mental disorder.[5] Impetus for developing an appropriate approach comes from the current florescence of theorizing about emotion and the self (Abu-Lughod 1986; Shweder and LeVine 1984; White and Kirkpatrick 1985). Although important data such as those collected by Lutz on the Ifaluk (1988) show that the locus of emotions may be primarily in situations rather than in the psyche, little cross-cultural work has concerned the emotional atmospheres that characterize such situations. Instead, it is often concerned with the density of lexical elaboration in ethnopsychological theories of emotion (Lutz 1982) or the degree to which emotions become "hypercognized" (Levy 1984). Less frequently, as in the work of M. Rosaldo (1984), have issues of *emotional experience* and feeling been raised, and only recently, in R. Rosaldo's (1989:2) elaboration on some remarks of C. Geertz (1973), have we heard much in anthropology on the cultural force of emotion. In Rosaldo's view, the notion of force refers to the kinds of feelings one experiences on learning, for example, that the child just run over by a car is one's own and not a stranger's. Rather than speaking in general about emotion as an abstract cultural system, one must consider the subject's position within a field of social relations in order to grasp the meaning of emotional experience. From this perspective the locus of disruptive emotional force in families of the mentally ill would be sought in the rupture of a particular intimate relationship and the violation of the self-systematic capacity for emotional protection. It is in order to move our thinking about self and emotion in this direction that I introduce the research construct of "expressed emotion," specifically developed to take such factors into account. I will describe the construct and critically assess its contribution to an agenda for the anthropological study of schizophrenic illness.

STUDIES OF SCHIZOPHRENIA AND "EXPRESSED EMOTION"

Originated in England by sociologist George Brown and his colleagues, "expressed emotion" (or EE) has come to refer specifically to criticism, hostility, and overinvolvement expressed by close kin toward a relative who suffers from schizophrenic illness. Although EE was originally conceived in much broader terms, a narrowed focus has developed in the wake of repeated empirical findings of a significant relationship between this constellation of factors and clinical relapse in the course of a schizophrenic illness. As a group, patients who live in households with high degrees of "expressed emotion" are significantly more likely to suffer a clinical relapse of psychotic symptomatology than are their counterparts in homes rated low on these factors (Brown, Birley, and Wing 1972; Vaughn and Leff 1976; Vaughn, Snyder, Jones, Freeman, and Falloon 1984; Karno, Jenkins, de la Selva, Santana, Telles, Lopez, and Mintz 1987; Leff, Wig, Ghosh, Bedi, Menon, Kuipers, Korten, Ernberg, Day, Sartorius, and Jablensky 1987).[6]

The research was initiated in the 1950s through a series of studies of the relationship between an individual's living situation following psychiatric hospitalization and patterns of recovery from schizophrenic illness (Brown, Monck, Carstairs, and Wing 1962). Brown had observed that patients who returned to live with family were rehospitalized more often than patients who returned to live in non-kin settings. He framed his interest in this problem in terms of a shift away from prevailing psychiatric assumptions concerning the etiological relevance of *psychopathological* (i.e., so-called "schizophrenogenic") family features to the identification of *everyday* family features that might figure into the course of major psychiatric disorder.

The beginnings of EE research were distinctly exploratory. Brown reports adopting an intuitive-inductive approach toward identification of qualitative aspects of family interaction and relationships that might be important in pathways to recovery (Brown 1985). Like Bateson, he was particularly attuned to tone of voice as a metacommunicational feature of family interaction. He commenced his search in a way compatible with the practice of anthropologists, through lengthy home observations and an open-ended interview, dubbed the Camberwell Family Interview (or CFI) after the London township where it was first used. The interview evolved

into a semistructured questionnaire format designed to elicit narrative accounts that were audiotape-recorded for subsequent analysis. The interviewer did not seek to elicit any particular set of information from a respondent; instead, the objective was to allow informants to speak in rich detail and great specificity about everyday aspects of family life. Especially noted are family patterns of interaction and relationship, including reports of irritability, quarreling, intimacy, and affection. Also queried are events leading up to the recent acute psychotic episode and psychiatric hospitalization. Following the interview, these narrative accounts were rated through use of emotion rating scales.[7] Brown assumed that nothing particularly extraordinary or unusual (i.e., pathological) would emerge from these queries; rather, anything of importance was to be discovered in the ordinary (nonpathological) features of family life and communication (Brown 1985:22):

> But such (pathological) families were in fact uncommon, and it seemed most unlikely that they could provide a general explanation for what we were observing. . . . [I]t seemed important that the occasional presence of *deeply* disturbed or unusual relationships between parents and patients should not be allowed to dominate our thinking. If I had any hunch about what was going on, it was that it often involved something a good deal less fundamental, indeed commonplace. Therefore one way forward would be to develop an instrument capable of recording the range of feelings and emotions to be found in ordinary families. Indeed, the family instrument used to record "expressed emotion" was not developed with the families of schizophrenic patients, and it did not occur to me that there was anything amiss in this. [Brown 1985:22; emphasis in original]

Implicit in this development of EE method is a parallel to the aforementioned work of Sullivan: just as for the latter there is a continuum between everyday mental disorder and serious psychopathology, for Brown there is a continuum between the feelings and emotions recorded in ordinary families of persons with schizophrenia. Here is a possible mediation between universalist and relativist positions on social response to mental disorder, for if demonstrably universal affective domains can be singled out, then some among them may prove especially relevant in cases of schizophrenic illness. This appears to be what Brown discovered, for as I have noted, among all the affective domains he explored, the trinity of criticism, hostility, and emotional overinvolvement stood out, not only in terms of frequency in the families of schizophrenic patients, but with respect to their association with the course of illness. This indeed is

the principal contribution of the EE paradigm to the anthropological question with which we are concerned, but while it is thus possible to hypothesize the EE domains as universal dimensions of response to schizophrenia, this is only half the story. The first step in a reciprocal anthropological contribution to the EE work is to identify the forms in which the construct's principal components might appear in other societies. A second step, beyond the scope of the present paper, will be to assess whether in fact they, and not other affective domains, are the most salient in particular cultures.

The Theoretical Impoverishment of the EE Construct: A Cultural Critique of "Prediction without Meaning"

In the past two decades, some two hundred journal articles have appeared on "expressed emotion." The topics of these articles are various, but prominently concern schizophrenic outcome (Brown et al. 1972; Vaughn and Leff 1976; Vaughn et al. 1984; Karno et al. 1987), therapeutic intervention studies (Falloon, Boyd, and McGill 1984), and impassioned critiques from the point of view of American family members who perceive researchers as blaming them for their relative's illness (Hatfield, Spaniol, and Zipple 1987). These studies have been applied to a range of illness conditions, psychiatric (e.g., schizophrenia, affective disorders, dementia) and nonpsychiatric (e.g., stroke, cancer, Parkinson's) alike. With respect to cultural diversity of application, the study of "expressed emotion" has fast become an international preoccupation within the cross-cultural psychiatric research community. Research is complete or under way in Europe (England [Brown et al. 1972; Vaughn and Leff 1976; MacMillan, Crow, Johnson, and Johnstone 1987; Tarrier, Barrowclough, and Vaughn 1988], Denmark [Day, personal communication, 1982], Italy [Cazzullo, Bressi, and Bertrando 1989], France [Barrelet, Pellizzer, and Amman 1988], Spain [Gutierrez 1986], and Germany [Kottgen, Sonnichsen, Mollenhauser, and Jurth 1984]), North America (among Anglo-Americans[8] [Vaughn et al. 1984], Mexican-Americans [Karno et al. 1987], and African-Americans [Moline, Singh, and Morris 1985]), Asia (China [Phillipps and Kleinman, personal communication, 1988], Taiwan [Wen, personal communication, 1988], India [Wig, Menon, Bedi, Ghosh, Kuipers, Leff, Korten, Day, Sartorius, Ernberg, and Jablensky 1987a, 1987b; Leff et al. 1987]), North Africa (Egypt [Wilson, personal communication, 1988]), and Australia (Parker, Johnston, and

Hayward 1988). In short, "expressed emotion" research has been exported to a host of populations.

Given this state of affairs, it might be expected that the extension of EE research reflects the empirical testing and theoretical elaboration of a well-developed set of assumptions concerning the nature and meaning of the construct. Distressingly, this is not the case. The paradigm's most serious shortcoming from an anthropological point of view is its capacity for "prediction without meaning," already identified some fifteen years ago by George Brown, himself.[9] Empirical approaches in psychiatric research typically do not concern themselves with questions of interpretation or meaning. Thus, although the predictive power of "expressed emotion" studies resides in the repeated demonstration of significant association between EE and clinical relapse, little has been done to articulate a theoretical framework for this research. In the case of "expressed emotion" research this presents a problem, since explication of EE, as an empirical index of relatives' subjective experience and response, requires a theoretical bridge from behavior to meaning.

Also striking from an anthropological point of view is the neglect by EE researchers of an examination of the relationship between culture and expressed emotion (Leff and Vaughn 1985). Further, it is apparent that when culture is introduced it is conceived in remarkably impoverished ways (Koenigsberg and Handley 1986, for example). Since the anthropological literature of the past several decades has documented substantial differences in such essentially cultural features as the ethnopsychology of emotion, communicative styles, psychodynamics, ethnomedicine, and kin relations and social support, we would reasonably expect that features such as these are of key relevance to the explication of expressed emotion (Sapir 1961; Sullivan 1962; Shweder and LeVine 1984; Schieffelin and Ochs 1986). Indeed, in my view, these are the very grounds onto which EE researchers have stumbled. Yet current explanations for differences in expressed emotion profiles have not significantly advanced beyond Brown's early and tentative suggestion that EE was perhaps linked to patient psychopathology, relatives' personality characteristics, or a combination of these two factors (Brown et al. 1972). Hooley (1987) offers a more recent version of the personality-based formulation. Her contribution is to suggest that relatives' personality characteristics should be analytically distinguished by their

tendencies to attribute blame either to the patient or to the illness. However, a personality, attributional, or psychopathology model for the conceptual understanding of expressed emotion remains insufficient.

Vaughn (1986) has taken a step toward cultural analysis by identifying four characteristics that differentiate British relatives on the scales for expressed emotion. These relatives are said to differ in their (1) respect for patients' relationship needs; (2) attitudes toward the legitimacy of the illness; (3) level of expectations for patient functioning; and (4) emotional reaction to the illness. For example, a relative is considered low in EE if he or she generally respects the patient's need for social distance or nonintimate communication, considers the problem to be illness-related and, therefore, outside of the control of the individual, holds reduced expectations of functioning due to perceived disability, and displays a concerned but "cool," "easygoing," or "flexible" response to the problem (Leff and Vaughn 1985). That such dispassionate traits (e.g., remaining "cool") are held in high esteem within English culture is well known. It is obvious to anthropologists that this culturally specific interpretation of "low expressed emotion" cannot be expected to provide a template for cross-cultural analysis that could elucidate the essential nature of this construct. As a colleague once remarked to me, "leave it to the English to decide that emotion is a problem." Certainly it is tempting to conclude that the expression of anger as socially bothersome is a distinctively British problematic. Cross-cultural review of ethnotheories about anger makes it equally clear, however, that the expression of anger is often culturally configured as problematic. Provisos regarding "too much" or "too little" anger are commonplace. Thus the expression of anger generates cultural trouble, be it Inuit, Ilongot, or turn-of-century Viennese trouble. In many Latin-American traditions, anger and hostility, whether expressed among intimates or in witchcraft, are believed to cause serious, sometimes life-threatening, illness.

A selective integration of EE into anthropological research, therefore, requires careful analysis of its conceptual components, for behind the questions about implicit and explicit theoretical underpinnings of expressed emotion lies the issue of the scope of its validity for comparative work. Although the researchers of the British and Anglo-American studies felt that their work constituted a cross-cul-

tural comparison (Vaughn et al. 1984), the value of this work invited analysis across a greater cultural distance. Accordingly, my analysis is grounded primarily in a study of Mexican-descent families,[10] with additional reference to the limited body of cross-cultural EE studies completed to date. Following a description of the basic outlines of the study, I examine the principal components of EE for their contributions to an anthropological approach to schizophrenic illness.

EXPRESSED EMOTION AND THE COURSE OF SCHIZOPHRENIA AMONG MEXICAN-DESCENT FAMILIES

The potential import of the EE factors in culturally and linguistically distinct family settings motivated the longitudinal study undertaken among a group of predominantly monolingual Spanish-speaking immigrant Mexicano families living in California.[11] Of further import in doing this work with a Mexican-descent population is the highly elaborated family orientation among Mexicanos. Throughout the literature on Mexican, Chicano, and Mexican-American culture, no single observation is more often made than that of the overwhelming importance of the family for an individual's identity and emotional well-being (Gaviria and Arana 1987; Ramirez and Arce 1982). Indeed, as is more broadly true of numerous Hispanic groups (Murillo 1976), an individual's sense of self—in broadest terms, what I take to be the culturally determined capacity for, and style of, engagement in the world and with others—can productively be considered as "sociocentric" (Shweder and Bourne 1984) or "indexical" (Gaines 1982) generally, and strongly kin-oriented in particular. Thus, as a family-based method, EE research holds particular relevance for this population. If a factor such as expressed emotion were to play a crucial role in illness processes, it seems likely that it would be observed in this cultural group.

Another way to appreciate the significance of the problem is to consider that, from a cross-cultural perspective, family settings constitute the most common living situation for persons with mental disorder. Among many ethnic and immigrant groups in the United States, including Hispanics, kin residence prior to and following psychiatric hospitalization for an acute psychotic episode is typical. Moreover, in the wake of deinstitutionalization and inadequate

community residential programs, a broader American pattern of kin residence following psychiatric hospitalization has become increasingly common. This residential trend means that the relatives of patients are increasingly finding it necessary to cope with the day-to-day realities and difficulties generated by living with schizophrenic illness (Jenkins 1988b).

Although the principal elements of the expressed emotion construct—criticism, hostility, and emotional overinvolvement—are by no means absent from Mexican-descent families, use of the EE scales required adaptation to account for culturally specific patterns of family relations. Prior to beginning the five-year study,[12] a one-year pilot project was completed to translate the CFI into Spanish and to consider issues of cultural adaptation for use of the expressed emotion rating scales.[13] The pilot experience also served to confirm the expectation that the Spanish version of the CFI could be administered with facility to Mexican-descent relatives. At least three factors seem to account for the successful use of this interview. First, the free-form conversational style adopted by this interview format as obtained in the home setting seems to have promoted rapport and generated a comfortable and natural narration of family life. Second, the strong family orientation of these Hispanic relatives seems to have engendered their interest and willingness to engage in lengthy discussion about an ill family member. Finally, almost invariably, no one in the health care system—be they clinical or research personnel—had ever made a request to hear the family members' thoughts and feelings about the situation. Since relatives generally felt they had much to tell and no one to tell it to, research visits to the family home to talk about the recent hospitalization were perceived by family as a valued opportunity to narrate their story.

Although substantial intracultural variation exists among Mexican-descent populations, several cultural ideals can be outlined to gain an understanding of the culturally distinct features of this population. Mexican-descent families have often been characterized as cohesive social units that are protective of their members. Interpersonal relations characterized by *dignidad* (dignity) and *respeto* (respect) are considered essential to the maintenance of family harmony (Murillo 1976; Keefe and Padilla 1987). Moreover, traditional differences in affective and behavioral response patterns are often gender-specific within families: although men and women may

jointly share family responsibilities and decision making, fathers are said to be the principal source of discipline and mothers are expected to be devoted to their family's welfare (Canino 1982).

In my view, another feature of Mexican and Mexican-American culture is a tendency to recognize and endure existential sources of suffering more than, for example, Anglo-Americans, whose cultural expectations incorporate values of the pursuit of happiness, self-realization, and triumph over life trials and obstacles. This observation should in no way be taken to mean that Mexican cultural traditions can be characterized by resignation or fatalism. In our study of 70 patients and their families, relatives often reported expectations of cure and mobilized their help-seeking efforts to that end. When faced with serious or long-term illness, however, they may come to accept such conditions with equanimity without relinquishing hope of recovery. I turn now to an examination of the two principal components of EE (criticism and emotional overinvolvement).[14]

AN ANTHROPOLOGY OF CRITICISM

Linguistic and Paralinguistic Dimensions of Verbal Criticism

In the expressed emotion method, criticism is identified on the basis of the content and/or vocal characteristics of speech (Brown, Quinton, Rutter, and Vaughn 1978). For a critical comment to be rated on the basis of content, there must be a clear and unambiguous statement that the respondent dislikes, disapproves of, or resents a behavior or characteristic. For vocal characteristics that index critical comments, the rater considers tone of voice, pitch, and intonational contour. Such vocal markers, though their use varies from culture to culture (Irvine 1990), are observed to function in many languages as what Goffman termed "keying devices" to mark specific activities, distinguishing, for example, between teasing and criticism (Ochs 1986:4–5).

In Spanish, as in English, both content and vocal characteristics of speech may convey criticism. We therefore found it appropriate to focus on these features for the display of critical affect. One striking tendency emerged. During the pilot year of administration and rating of the CFI, we observed a common way to convey criticism

by reference to anger, typically *me dio mucho coraje* (it made me very angry), although we noted other variations, such as those using the verb *enojarse* (to be annoyed, angry). The frequent use of these phrases to communicate criticism is indicative of the role of anger in Mexican family contexts, that is, to signal strong disapproval or annoyance. Such comments were also almost invariably made in a critical tone of voice. We therefore considered anger-related statements to be culturally specific ways of communicating critical affect in a way unparalleled by the British or Anglo-American studies of criticism. Among those cultural groups, investigators reported that a typical way for relatives to make a criticism was in reference to dislike, without necessarily making a direct reference to anger (Brown et al. 1972; Vaughn and Leff 1976; Vaughn et al. 1984).

Each criticism is recorded and tallied upon completion of the interview. In most research to date, the cutoff score for qualifying as "high" in expressed emotion has been derived empirically in relation to outcome.[15] The mean number of critical comments for Mexican-American relatives (3.3) was significantly lower than their British (7.5) and Anglo-American counterparts (6.9). These differences in the numbers of critical comments suggest cross-cultural variations in levels of criticism in the homes of persons with schizophrenic illness. However, to understand these variations, the substantive domains in which criticism is expressed must be specified. This question concerns whether, in cross-cultural perspective, relatives are critical of the same kinds of things (e.g., hearing voices, "laziness"). Researchers from the British studies recently presented results from their sole attempt at content analysis and have surprisingly argued that all critical comments can be subsumed under only two categories: "enduring personality traits," which account for 70 percent of all criticisms, and "symptom behaviors," which account for the remaining 30 percent (Leff and Vaughn 1985). This is a problem since (1) the analysis is embedded in Anglo-American ethnotheory that tends to explain cultural rule violations (as recorded in criticism) with reference to personality attributions; and (2) the category of symptom behaviors remains unanalyzed, presupposing the clinical definition of psychiatric symptoms and not reflecting indigenous definitions of troublesome behavior.

The British system of content analysis differs considerably from the coding scheme developed for comparative analysis of a matched

sample of lower socioeconomic status Mexican-American and Anglo-American EE data (Jenkins, Karno, de la Selva, and Santana 1986). This analysis established a total of 22 coding categories for the Mexican-Americans and 31 for the Anglo-Americans.[16] This sorting process indicated that categories of critical comments varied—indeed some were not paralleled—across cultural groups. Moreover, there were major cultural differences in what relatives were complaining about. Among the Mexican-American relatives, 39 percent of all critical comments were aimed at behaviors that were disruptive or disrespectful of the family, as compared to 27 percent of the Anglo-American relatives. Also, Mexican-American relatives displayed a lesser concern with negative personality traits and psychotic symptom behaviors compared to their Anglo-American counterparts. The latter point can be taken as empirical support for the proposition that Hispanics tend to be tolerant of psychotic symptomatology (Fabrega, Swartz, and Wallace 1968; Rogler and Hollingshead 1965; WHO 1979). An important cross-cultural difference was also found for criticism of inactivity and unemployment. Mexican-Americans who were critical of the patient's unemployment stated flatly that they wanted or needed the patient to work in an income-producing job. Anglo-Americans made the same basic request in a somewhat different manner. Their accusations were likely to incorporate beliefs about faulty character traits: laziness; lack of ambition, motivation, or achievement-orientation; inability to "settle down to one thing"; and the like.

He just didn't have no ambition to do anything. And I kept telling him, "Well do this, do that," you know, and he's threatening. Twenty years old, right in his prime. But now he should be involved but he's not. He would just sit there in the chair and watch TV all the time. . . .

She's too darn lazy. That's her trouble.

No ambition. Doesn't care for nothing. I should say doesn't care for anything, class up my English. The way I said it was to emphasize that worthlessness of his. Useless.

Only one (considerably milder) remark of the above nature was made by a Mexican-American relative. Although the majority (72%) of the Mexican-American key relatives were not considered highly critical, the following case study exemplifies the nature of critical comments among those who were.

A Profile in Criticism: The Father and Mother of Zenaida

The parents of 25-year-old Zenaida Serrano exemplified the concern for a smoothly functioning family unit. This ideal has been sorely tested in the face of the difficulties generated by Zenaida's typical behavior. The father, Sr. Serrano, made seven critical comments about his daughter during the course of the interview. All his criticisms focused on various kinds of behavioral deviance: argumentative, destructive, disrespectful, and deviant behaviors. The father also complained that his daughter seemed to nag him about a great many things, especially questioning his love and affection for her. This he regarded as silly, and while he would snap at her about such accusations, he nonetheless took the time to reassure her that she was indeed loved and wanted. Other behaviors were more disturbing to the father, however. These included Zenaida's tendency to throw objects around the house and the additional facts that she slapped her mother on one occasion, that she would go outside of the house in her bathrobe, and that she would insult him through rude and obscene language: *"Y me sacó a mi madre, y me dio más coraje!"* (And she insulted me [with reference to my mother] and made me angrier.)

Sra. Serrano made five critical comments about her daughter during the course of her interview. These comments were similar to those made by her husband. She criticized Zenaida for slapping her, for quarreling or fighting with the family, for behaving in a disrespectful way, and for behaving in a very strange *(raro)* way. When Zenaida once questioned her mother as to why it should be that she was scolded more frequently than were her siblings, her mother replied: *"Siempre estás peleando con los demas! Por eso hay mas motivo para regañarte!"* (You are always fighting with the others [siblings]! Therefore, there is more reason to scold you!) Sra. Serrano also considered Zenaida's lack of proper respect for the family as a source of consternation: *"Portándose muy mal con nosotros ella, ya nos perdí por completo el respeto, y entonces eso era muy mal que estaba haciendo ella."* (She was behaving very badly with us, lost respect for us completely, and [then] that was very bad what she was doing.) The example of a strange *(raro)* behavior criticized by Sra. Serrano: *"Ella quiere besar el niño de dos anos y besarlo en la boca! Le dije que no era correcto besar a un niño en la boca!"* (She wants to kiss the two-year-old child and kiss him

on the mouth! I told her this wasn't right to kiss a child on the mouth!) This unusual behavior clearly mortified the mother, who demanded an account for her daughter's strange act. Zenaida replied that she was desirous of knowing the sensation of kissing a man and wanted to try it out with this young child. The mother's response reflected her consternation and incredulity: *"Ay, Dios mio!"* (Oh my God!)

Despite these trying behaviors, this family considered it their responsibility to care for their ill family member. For example, the father of Zenaida disagreed with professional staff who had repeatedly advised him that she be placed in a board-and-care facility, given their perception of the amount of trouble that she had caused for the family. Sr. Serrano, on the other hand, viewed the care of his daughter as his family's responsibility. Sra. Serrano voiced her concern that Zenaida needed "a mother's love" and that certain unscrupulous persons might take advantage of her daughter. She explained to me that people who are very ill with *nervios* can become debilitated and vulnerable and in need of protection. Sr. Serrano agreed, adding that the possibility of Zenaida's becoming pregnant were she to live outside the household would only add to his financial burden since, in his view, the child would clearly be his responsibility. Interestingly, the treatment staff at the psychiatric facility Zenaida had used took a different view: as far as the staff was concerned, the Serrano family had repeatedly "sabotaged the treatment plan" by failing to agree to her placement in a board-and-care facility. The staff particularly complained that Zenaida's parents seemed unable to comprehend that their daughter, as "a chronic schizophrenic," was unlikely to improve. Zenaida's family maintained that, despite their daughter's strange and upsetting behaviors, they missed her when she was gone (for brief hospitalizations) and that only God knows if and when Zenaida will improve. They hold fast to their faith and hope that she may.

This case example is illustrative of the complex interrelations that constitute an intrafamilial emotional atmosphere. For example, despite the fact that Zenaida's father was more critical than most of the other Mexican-descent relatives in the study, he simultaneously expressed warmth and affection for his daughter. He displayed no hostility toward his daughter but seems to have become exceedingly

firm when he felt his daughter had crossed the line of acceptable moral comportment in a family context.

Critical Comments as Complaints about Cultural Rule Violation

As the above case shows, the behavior of persons with schizophrenic illness can violate a host of cultural norms and proscriptions. This is perhaps why, in some societies, the same term is employed for the mentally ill and for young children, indicating that such disturbed persons are not fully socialized (H. Geertz 1959; Myers 1979). Edgerton (1978:466) has observed that while societies may allow for acceptable diversity in some human conduct, one knows "when the limits of acceptable variation have been exceeded because the result is 'trouble' in the form of complaints, disputes, accusations, recriminations, and the like." Critical comments may be viewed in this light as complaints about the perceived violation of rules that persons with schizophrenic illness may engage in with disquieting regularity.[17] In this regard, it should be noted that Bateson and his colleagues (1956) argued that confusion about rules is central to schizophrenia. Shweder (1980:86) has underscored Freud's identification of "criticism (and related activities such as accusing and accounting) as the primary activity associated with rules." Also relevant is Lutz's (1982) analysis of emotion words among the Ifaluk in Micronesia. Her data show that situations are evaluated with reference to which cultural values have been violated.

I am convinced that the critical comments component of the expressed emotion research can become valid for cross-cultural research only if grounded in a generalizable definition of criticism as negative affective response to perceived cultural rule violation. In Leff and Vaughn's (1985) conceptualization, the Anglo-American cultural preoccupation with personality is embedded in the theoretical presuppositions such that their informants' emphasis on personality as a domain of criticism is taken for granted, and both data and analysis are couched in terms of personality. Researchers conclude that personality traits of relatives (e.g., tolerant-intolerant, good-bad) lead them to make personality attributions (e.g., lazy, stubborn) about their ill family member. The unidimensional and tautological reasoning of this paradigm is framed by the overarching explanatory construct of personality. This psychological-psychiat-

ric explanation is a remarkable example of personality theory writ large and is entirely consistent with Anglo-American ethnotheory that tends to explain things gone wrong through reference to personality traits. While a significant proportion of the critical comments made by the English-speaking relatives do appear as negative personality attributions, careful analysis reveals this to be only a partial account of the problem. This example serves to underscore how, in the absence of cross-cultural comparative analysis, conceptual analysis can amount to nothing more than the reification of cultural categories (Kleinman 1988).

My analysis of criticism as kin objections to cultural rule violations is based on a definition of a rule as "shared understanding of how people ought to behave and of what should be done if someone behaves in a way that conflicts with that understanding. Rules, then, prescribe or proscribe behavior . . . and have a regulatory sense" (Edgerton 1985:24). As Edgerton has pointed out, rules may be understood in terms that are definite or indefinite, explicit or implicit, grave or trivial, simple or complex. They may be formulated as personal routines, conventions, secular regulation, moral principles, or supernatural injunctions. For the anthropology of criticism, however, we must focus not on the nature of rules, per se, but on the nature of violation. Criticism may be appropriately directed at a relative if that relative has actually violated a rule that would be recognized as such by any cultural member. Criticism may also be leveled, however, if it is only perceived that such a rule has been violated, if the consequences of the criticized person's actions are exaggerated, or if those actions are only imagined or even concocted. In addition, the rules violated may not be conventional, but idiosyncratic: "Never, ever leave the coffeepot on the left side of the stove." It is certainly conceivable that a situation may arise in which a person is criticized much more harshly for violating an arbitrary domestic rule of this kind than for having committed a violent crime outside the home.

It may be objected that to define criticism in terms of rule violation excludes, for example, criticism in terms of unacceptable personality attributes. However, if we examine the content of personality-based criticisms, they are invariably framed as habitual violations of cultural rules. One is criticized for being lazy or stubborn because it is wrong to be lazy or stubborn. Among Anglo-Ameri-

cans, what relatives of patients object to is failure to be an active, productive, independent member of society, all of which are rule-based cultural prescriptions.

Even granted this definition of criticism, there may be limits to its cross-cultural utility if it is shown that there are cultures in which kin do not criticize one another at all. While the ethnographic evidence on this question is uneven with respect to mental disorder, there seem to be a wide range of cultural settings in which some degrees and types of criticism are present, including Ireland (Scheper-Hughes 1979), China (Lin and Lin 1981; Wen, personal communication, 1988), Puerto Rico (Rogler and Hollingshead 1965), and Sri Lanka (Mendes, personal communication, 1987).

A suggestive example of an unaccepting and possibly critical or rejecting affect, despite a sociocentric sense of self and strong cultural prescriptions for love and compassion toward kin, is noted in the work of Myers (1979) for the Pintupi Aborigines. Myers has noted the overwhelming salience of the concept of *walytja* (compassion for kin, or shared identity) and a specific view of the self based on shared identity connected with a "web" of significant others that European observers would describe as external to the self. In this context we might imagine that a person with mental disorder would be the object of compassion and be integrated within the community. However, Myers reports an example of an individual's strategic use of this cultural orientation to his own personal advantage:

> That the concept of "compassion" is best understood as the notion of being moved by another's wishes or condition is expressed by one man's hope that the doctors would take away his insane wife. They should not, he said, feel sorry for her *(ngalturrinytja wiya)*, but should do what *he* wanted (i.e., have compassion on *him*). [1979:356; emphasis in original]

In this incident, we may detect traces of a critical attitude even though compassion is the predominant affective ideal and even though a sociocentric self would seem to preclude self-interest. While this may not be the strongest form of evidence, it suggests that if it were looked for, criticism might even be found among such a compassionate people as the Pintupi.

The larger issue of the relativity or universality of forms and types of criticism is a matter for empirical determination, and I can suggest three guidelines for such an inquiry. First, if criticism is defined in terms of rule violations, are there rules that exist universally? Edgerton (1985) suggests that there may be some, such as proscrip-

tions of violence and prescriptions for cooperation. Shweder (1980) has also outlined types of rules that may be universal. Second, we need to know the full range of response to rule violation, such that we can identify not only the presence or absence of criticism in a particular society, but its cultural salience or "weightiness" in particular settings. Criticism culturally defined as berating, as punishment, or as normative mode of interaction may not be comparable at all. Third, criticism cannot be understood apart from cultural definitions of the self. With respect to rule violations, the crucial issues are agency, autonomy, and accountability for behavior, as well as beliefs about the possible effects of one's actions on others. In sum, a thoroughgoing anthropology of criticism is necessary for further cross-cultural elaboration of ideas emanating from the EE paradigm.

CULTURE, SELF, AND EMOTIONAL OVERINVOLVEMENT

The term *emotional overinvolvement* (EOI) refers to a diverse set of behaviors and attitudes of unusually self-sacrificing and devoted behavior, extremely overprotective behavior, and intrusive behavior. The rating is assessed by a six-point scale (0–5). Specific behaviors are considered "overly" or "unusually" involved with respect to what constitutes normative kinds of behaviors in a particular kind of situation, that is, the family management of schizophrenic illness. The approach used in the Mexican-descent study was to consider behaviors as emotionally overinvolved only if considered culturally unusual within the relevant sociocultural context. For example, among Mexicanos and Mexican-Americans, a high degree of involvement in family affairs by household relatives is culturally characteristic. We expected that this would be no less so in a situation of serious family illness. This led us to assume that the way in which high degrees of emotional overinvolvement were manifest among Mexican-descent relatives could not be the same as reported for the British or Anglo-American families (Brown et al. 1972; Vaughn and Leff 1976; Vaughn et al. 1984). According to the British criteria, for example, behavior would be considered exceptionally devoted if a relative made daily visits to the hospital and brought homemade food to the patient. This would not be judged similarly by Mexican-Americans. Daily visits to the hospital are not regarded by family

members as excessive or sacrificial, and they are often expected from mothers. In our predominantly Spanish-speaking immigrant sample, mothers reported that frequent hospital visits were important, since this may have been their son's or daughter's first overnight stay away from home. They expressed concern over the experience of being sick in a geographically distant, English-speaking American hospital facility. Bringing familiar food to patients was considered a minor favor that could provide an ill relative with great comfort at a time of extreme distress.

The most notable finding for emotional overinvolvement is that a relatively small number of kin scored high (scores of 4 or 5) on this scale: only 11 (or 11%) of 109 relatives were noted as excessively or intrusively involved in culturally unusual ways.[18] Our results do not support specific ethnographic and clinical stereotypes in the literature of Latin-American women as typically "overprotective" and "self-sacrificing" (Canino 1982). These data are also important because they do not provide support for the notion that families of persons with schizophrenic illness are typified by disturbed or pathological interpersonal relations. Far from being the norm, our data, as well as that of the British and Anglo-American studies, indicate that such characterizations are incorrect.

For those relatives who *were* considered unusually or excessively involved, qualitative features of self-sacrificing and overprotective behaviors were again culturally distinctive compared to previous studies (see Vaughn 1986). Characteristic features of EOI among Mexican-descent families include: contemplation of suicide or death wishes specifically in reference to concern over the illness; endangering one's own life by risking or enduring extremely threatening or abusive circumstances (e.g., physical violence); severe somatic distress associated with *nervios;*[19] reports of depression, insomnia, and weight loss specifically in relation to the illness; chronic complaints of extreme suffering; living in chronic states of extreme fear, anxiety, and worry over the patient; significant changes in family activities and caretaking patterns (i.e., loss of family orientation and adoption of a nearly exclusive dyadic orientation with the patient); cessation of previous social activities to remain home at all times to "protect" the ill relative in the absence of circumstances warranting it, and, relatedly, vigilant or intrusive involvement with the patient in the absence of circumstances dangerous to the patient; and ex-

treme dramatization and emotional display in the narration of events.

Qualitative understandings of the rather distinctive phenomena of emotional overinvolvement have been notably absent in the expressed emotion literature, but are critical for the development of theory that can not only account for the sometimes exotic features of emotional overinvolvement, but can also address the ways in which it constitutes a situation of vulnerability for persons with schizophrenic illness. We turn now to the case materials to illustrate the particular nature of family relations characterized by high EOI.

Profile of Emotional Overinvolvement: The Mother of Francisco

Francisco's mother was rated as highly emotionally overinvolved with the illness of her son. She reported being so distressed by her son's illness that she had contemplated suicide in numerous ways, including shooting herself with a gun, throwing herself into oncoming traffic, and throwing herself down a staircase at home. Other family members reported that she had apparently attempted the latter method on at least one occasion. She maintained that she was unable to bear *(aguantar)* the situation for one more day. Throughout the interview she was tearful and emotionally distraught in talking about her son, despite the fact that he had recently experienced a dramatic relief from many of his psychotic symptoms and had come home from the hospital.

Francisco (age 21) had been hearing several hostile voices talking to him, believed people were trying to kill him, and was very fearful of going into crowds or leaving through the front doorway of his home. He also reported that he had difficulty with his thinking: he would become confused and disorganized easily and frequently, was unable to concentrate, and believed he could influence other people with his thoughts. When I first met Francisco in the hospital I asked him what kind of trouble he had been having. He responded by telling me he had a "social problem" and that he was not the "sociable" type. He also complained that he had a problem with his thinking because he had a lot of thoughts and feelings that made him feel "stuck." After I explained the study to him, I asked if it would be alright with him if I came to visit him at home and interview some of his family members. He agreed to this and asked me if I wouldn't mind telling his mother and oldest sister that they should leave him

alone and stop bothering him. He claimed that it didn't help him to know that they were always worrying about him, listening in on his telephone calls, following him down the street when he'd leave to buy cigarettes, and refusing to let him see his friends.

Francisco's mother described herself as having enjoyed music, singing, and socializing with others prior to the onset of her son's illness, but that her interest in these activities had now faded. Suffering *("sufrir, puro sufrir")* had come to occupy a central role in her life, and she made it clear that her life had been dramatically altered. She told me that her sole task in life now was to take care of him, saying, *"yo lo cuidaba como una perla o un diamante"* (I take care of him like a pearl or a diamond). This involved following him around the house at home and never letting Francisco out of her sight. She claimed she did this to ensure nothing "bad" would ever happen to him. If he was late on a routine errand or a visit to a friend, the mother would fall to the floor and have an *ataque de nervios* (severe attack of nerves; see Guarnaccia and Farias 1988), in which she wailed loudly and talked rapidly and unintelligibly about how unbearable her life has been. Other family members told me that they considered their mother's behavior unusual and extreme. While *ataques* can commonly be expected to occur in response to serious situations (such as death, very bad news, severe family conflict), they considered their mother's frequent bouts with them, in response to minor incidents, to be a problem. Francisco's mother was rated high on the emotional overinvolvement scale because of her severe problems with *nervios* and *ataques de nervios;* suicidal episodes; overprotective and intrusive observations of her son's behavior; preoccupation with her son's problem to the exclusion of her previous social activities; lack of objectivity; exaggerated and typically dramatic narrations; and because of the family's concurrence that their mother's behavior was unusual and troublesome.

Profile of Emotional Overinvolvement: The Father of Gabriella

Another case of high emotional overinvolvement is that of Sr. Vasquez, the 69-year-old father of 18-year-old Gabriella. The onset of his daughter's illness reportedly began in her early teens, when she would cry and scream throughout the night. On several occasions she was taken by her father to see *curanderos* (healers) in Tijuana (border town between northwest Mexico and southern Cali-

fornia). *Curanderos* agreed that her condition was due to "female trouble" and was specifically related to the onset of menstruation. Her symptoms included auditory hallucinations, irritability, insomnia, and violent-destructive behavior (e.g., breaking a window, hitting and shoving family members).

Sr. Vasquez lives in East Los Angeles with his daughter and four younger children. He describes himself as "both mother and father to my children," since the mother is said to have "deserted" the family. Sr. Vasquez expressed his view that his daughter's mental illness was explained in part by the fact that she is *"fuerte de naturaleza"* (has a strong sexual or physical nature). However, Sr. Vasquez also understood his daughter's problem as the result of having grown up in a home environment where her mother is said to have had various lovers who would "hold and kiss her" in front of Gabriella. According to Sr. Vasquez, his daughter would be much better off if she were married because he feels it is important for her to be active sexually. During the course of the home visits, he mentioned several times that Gabriella has asked him to make love with her, and that he has had to push her away because she clings to him and kisses him in a way that is inappropriate for a daughter to behave with her father.

Despite Gabriella's relatively severe symptoms, she had been able to go to school and was particularly interested in friends and in social and church activities. The father cautioned against all such activities, insisting that she stay home and be taken care of by him. Even though the father had a young girl who came daily to help with cooking and child care, he also felt that his daughter should be at home to take care of him since he was almost completely blind. He reported that the way he took care of *her* was to keep his arm around her all day long *("todo el día la traía del brazo")*. He stayed with her constantly, helped her to dress, eat, and especially insisted on helping her go to the bathroom. (His rationale for this kind of "shadowing" was that Gabriella had once thrown a sanitary napkin down the toilet and clogged it up.) He also slept with her throughout the night, his arms around her constantly. His reason for doing this, he asserted, was to protect her from leaving the house and possibly getting into trouble, despite the fact that she had never attempted to do so. He was direct in claiming that he slept with her to protect her, and certainly not to abuse her sexually. The younger 16-year-old

sister, who was also interviewed, reported that she thought this behavior was strange, since most of her friends' fathers did not sleep with them. Throughout his narration of events he was very dramatic, frequently punctuating his points with *"Ay Dios," "Valgame Dios!" "Es mi hija, yo la quiero. Me apuro por ella"* (God; Give me a break, God; It's my daughter, I love her; I have suffered because of her). He reported that he has lost sleep worrying about her, thinking of ways he can control her and keep her from leaving the house.

Several features of this father's behavior and attitudes were considered evidence of a high degree of EOI. These include his dramatic narration of stories illustrating his apparently exaggerated emotional response to events in the past. For example, because (18-year-old) Gabriella failed to hold his hand when crossing the street, he described having a virtual *ataque de nervios*. This transpired despite the fact that no serious situation of danger or threat had occurred. Sr. Vasquez also demonstrated marked concern, reflected in unusually self-sacrificing, devoted, and extremely overprotective behavior. Despite the fact that Gabriella's active social life outside of the home took place without incident and was a great source of satisfaction to her, the father insisted that she stay home and be taken care of by him. Within the context of the Mexican-descent sample of 109 key relatives, this father's method of "caretaking" was highly unusual, reflecting a high degree of emotional overinvolvement: staying with her constantly, keeping his arm around her, helping her to eat and dress, and sleeping with her thoughout the night.

Emotional Overinvolvement as the Behavioral Transgression of Boundaries

The notion of emotional overinvolvement focuses on overprotective and self-sacrificing behaviors. In actuality, high degrees of these behaviors are less frequent than are high degrees of criticism among relatives interviewed in the expressed emotion studies.[20] When such instances do occur, however, the behavioral portrait appears to resemble constructs in the family therapy literature, such as "enmeshment" and "symbiosis" (Goldenberg and Goldenberg 1980; Minuchin 1974).[21] These terms presuppose a culturally specific notion of the self as a bounded entity, but the defining characteristic is that these boundaries have been pathologically surpassed. Aside from the conceptual domain they cover, however, concepts such as "en-

meshment" differ from "emotional overinvolvement" in two important ways. First, the concept of EOI is an empirically derived, global measure that is based on specific types of evidence gathered within a research interview situation. Thus, EOI is not equivalent to more clinically obtained judgments made within specifically therapeutic situations. Second, and perhaps most important, these concepts differ substantially in how they have been applied: concepts such as enmeshment and double bind have been formulated to account for presumed family *etiological* features of schizophrenia, whereas emotional overinvolvement has been confined to features that have been empirically associated with the course of illness (Jenkins 1992).

Here is the arena in which the cross-cultural validity of the EOI concept must be scrutinized rigorously, for in order for the required transgression of boundaries to be possible, let alone pathogenic, the cultural psychology[22] of a people must include some kind of a bounded self. In approaching this problem, several points must be made. First, from the viewpoint of emotion, kin relationships can be understood as constituted precisely with respect to such boundaries, say in contrast with a jural viewpoint that defines them in terms of rights and responsibilities. Second, it is doubtful that there exists a culture in which the self is entirely without bounds in some minimal sense. For example, fieldwork with Salvadoran refugees in Boston and the clinical presentation in recent years of refugees and victims of torture from all parts of the world suggest to me that trauma and torture are invariably events for the self (cf. Jenkins 1991; Jenkins, Kleinman, and Good 1991; Mollica, Wyshak, and Lavelle 1987).[23] In addition, the universal existence of an incest taboo argues for the presence of boundaries for the self—not incidentally, many cases rated high in emotional overinvolvement lie on the threshold of incest. Third, though emotional overinvolvement typically occurs in a small proportion of cases, it exhibits a remarkably coherent constellation of features across the cultures in which it has been documented. Given these observations, cross-cultural validation of the concept must still begin with the question of whether particular cultures have a concept of self that is a prerequisite to this psychocultural dynamic before proceeding to a more detailed search for cross-cultural variability in societies where emotional overinvolvement is in fact observed.

An initial hypothesis might be that EOI will be found only in societies in which the emotional atmosphere is structured by nucleated households. Recent studies of expressed emotion in India, where extended kin households are prevalent, show the virtual absence of high degrees of EOI, though the methodological adequacy of this work remains in question (Wig et al. 1987a). However, Scheper-Hughes's (1979) data on schizophrenia suggest that EOI is very likely present among the Irish, and Briggs's (1987) data on attached-rejection behavior *(siqnaaniq)* toward vulnerable children suggest the same for the Inuit. Moreover, both these societies appear to possess the kind of repertoire of ethnopsychological concepts necessary even to respond to a research protocol like the CFI that measures emotional overinvolvement. A culturally informed analysis will be prepared to recognize evidence of EOI in idioms other than those familiar in Anglo-American culture, idioms such as witchcraft or demonic possession. Indeed, though their discussion must be saved for a separate paper, reanalysis of the Mexican-descent cases showed attribution of demonic influence to be present in five of ten cases.

A key methodological point about EOI on the part of relatives is that it is not linked to, or explicable by, the objective severity of the patient's behavioral disturbance. Instead, it has much more to do with relatives' subjective perception of how heavy a burden the illness places on the family (see Noh and Turner 1987 for review of "family burden"). The relative rated high in EOI might say, for example, "I am completely overwhelmed by this" or "My whole life is looking after Juan," whether or not Juan objectively requires such looking after. Relatives who were highly emotionally overinvolved would complain to us that their lives were miserable and filled with suffering. Indigenous recognition of such an attitude and its accompanying behavior as pathological is clearly critical to the cross-cultural validity of the concept. It is, accordingly, important that in our study other household members did not praise emotionally overinvolved behaviors with statements like "she's a saint." Rather, they were likely to tell us things like "that's too much" or "my mother's lost it." Since Mexican-descent families strive toward a cultural ideal of harmony and contentment within the household, such conflict was typically regarded as disruptive of family life. This indigenous identification of EOI-related behaviors as unusual provides

support for the cross-cultural validity of the concept within this context.

In addition, social-ecological features such as household size, isolation, and economic dependence may be implicated, as suggested by a study that showed that high EE level more accurately predicted relapse in one-parent households where there was a poor premorbid history (Parker et al. 1988). It is also important to note here that EOI is significantly gender-related. Nearly all relatives considered to be high on this factor are female and all patients male. The fact that this occurs primarily among women is not surprising in light of the elements it taps, namely, degrees of affective involvement and caretaking, that parallel cultural prescriptions for women. It will be recalled that the one Mexican father who was considered high on this factor was a single parent who described his role in the family as "both mother and father to my children." Given the fact that we observed this kind of dynamic only in cross-sex family relations, it would be possible also to speculate on the existence of a sexualized dimension of the EOI phenomenon.

EXPRESSED EMOTION AND ETHNOPSYCHIATRIC CONCEPTIONS OF PERSONS AND ILLNESS

To what extent do cultural conceptions of mental illness mediate expressed emotion in families? Can such conceptions create a culturally legitimate status that inhibits high levels of criticism and/or emotional overinvolvement? From a relative's point of view, is the cultural locus of the problem deemed to be a "person" or an "illness entity"?[24] Among the majority of Mexican-American families, the concept of *nervios* (nerves) serves as a cultural label for schizophrenic illness. Since severe cases of *nervios* are not considered blameworthy, or within an individual's control, the person who suffers its effects is deserving of sympathy, support, and special treatment.

> The complex of cultural notions including sadness, *nervios,* and tolerance provides the cultural logic in terms of which Mexican-American families adapt to the illness through sympathetic inclusion . . . [and] the families in this study did not adopt the much more severely stigmatizing label for "craziness," *loco.* As a *loco,* the individual is considered to be completely out of control, with virtually no chance of recovery. [Jenkins 1988b:321–322]

Anglo-Americans explicitly dismissed the parallel English term "nerves." They were likely to consider the problem as "mental" in

nature, often preferring biomedical labels such as "schizophrenia" and personality attributions such as "lazy" (Jenkins 1988a).

While such fundamental conceptions may provide overarching cultural frameworks that facilitate particular social responses, many other complex processes of response are also brought into play. Even if "illness" serves as a central interpretive frame for understanding and responding to the problem, certain actions on the part of the afflicted may require alternative interpretations. For example, even if kin believe that the difficulties their relative has suffered are due to *nervios,* the afflicted person, nonetheless, will be held accountable for highly objectionable behaviors, such as disruptiveness, destructiveness, or aggression, within the family context. Such transgressions are considered so grave that social response is not principally filtered through an illness frame as much as a moral frame. In such instances, there is an overriding sociocentric concern for family welfare and cultural values of *tranquilidad* (tranquility) and *respeto* (respect).

Conceptions of the problem among Caucasian Americans often incorporate biomedical diagnostic information that the person "is" a schizophrenic.[25] Paradoxically, a professional motive for this practice is to provide guilt-allaying, culturally legitimated scientific information to alleviate the families' frequently pernicious fears that they have "caused" the problem (Jenkins 1988a). Another professional motive is to mitigate the stigma attached to mental conditions through legitimating their biological (i.e., "real") basis and associated treatment interventions. Families are informed that it is a "biochemical imbalance." This knowledge ideally provides for "no-fault" insurance but, in practice, may constitute yet another personality characteristic subject to criticism.

It is perhaps not surprising that the term "schizophrenia" holds little cultural cachet among these Mexicanos and Mexican-Americans. Either culturally unimpressed or unfamiliar with the more medicalized notions of schizophrenia, these families almost invariably consider that their relative suffers from an illness, be it *nervios* or *algo de la mente* (something of the mind), but these persons are seldom reduced solely to an illness-identity (Jenkins 1988a, 1988b).

EXPRESSED EMOTION PROFILES IN CROSS-CULTURAL CONTEXT

Keeping in mind the anthropological critique worked out above for the principal components of expressed emotion, I return now to the question of overall differences in sociocultural response to mental disorder insofar as it can be addressed by the available body of cross-cultural EE data produced to date. Quite unlike Anglo-American relatives (Vaughn et al. 1984), the majority (72%) of Mexican-descent relatives (N = 109) were *not* observed to be highly critical of their ill family member. When collapsing the criticism and emotional overinvolvement scores to yield overall household "high" or "low" EE ratings, striking cross-cultural differences emerged: 41 percent of the Mexican-descent households were classified as "high" as compared to 48 percent of British and 67 percent of Anglo-American households (Karno et al. 1987).[26] Part of this difference may be accounted for by the observation that feelings of sadness, as conveyed through the content and tone of the Mexicano relatives' verbal behavior, would often pervade the interviews. The cultural thematic of sadness *(tristeza)*, sorrow *(pena)*, and pity *(lastima)* contrasted sharply with emotional responses characterized by anger, indignation, and frustration frequently displayed by Anglo-American relatives. This contrast is further sharpened when ethnic subsamples are matched for socioeconomic status. When lower socioeconomic status Mexicans and Anglo-Americans were compared, 43 percent of Mexican and 83 percent of Anglo households scored high in EE. This analysis suggests the mutual importance of social class and culture in accounting for variations in expressed emotion profiles (Jenkins et al. 1986).[27]

The Indian expressed emotion study (Wig et al. 1987a, 1987b; Leff et al. 1987) merits special consideration as both empirically important and methodologically problematic. Only 23 percent of the Indian families were classed as high, a figure that is significantly lower than the English, Anglo-American, or Mexican-descent studies. The relatively low Mexican-American mean score of 3.3 for criticism is still higher, for example, than the comparable figure of 1.83 for the Indian sample (Wig et al. 1987b). In the Indian study, *no* relative was rated more than 3 on the EOI scale, and for that moderate rating only three parents were considered to be overinvolved. Also, quite unlike EE studies in other cultural settings, in the Indian

study only hostility was found to be significantly associated with clinical relapse. The overall finding that 16 percent of Indian relatives were rated hostile is not dissimilar to that of other studies, where, for example, 18 percent of English relatives and 13 percent of Mexicanos were found to be hostile. However, hostility is typically a subsidiary factor that is usually rated only when there are high degrees of criticism; it is considered present in one of two ways: either as generalized criticism (e.g., "everything he does is wrong") or rejection (e.g., "for all I care, he can live on the streets"). In the Indian study only, both its presence and its association with clinical relapse were independent of criticism.

It is not clear how these Indian data might be interpreted. While the researchers have achieved acceptable levels of inter-rater reliability, the cultural validity of the protocol and rating scales used in Hindi remains to be established. That Wig and colleagues (1987a) specifically report no concern for cultural or qualitative issues in the application of this method is curious, suggesting to me that an anthropologically informed perspective in this study may have been lacking. The finding that only hostility (and not criticism or emotional overinvolvement) predicted outcome could signal the necessity of significant cultural adaptation of these scales for use in that setting. Leff and his colleagues (1987) acknowledge difficulty in employing the EOI scale based on what they regard as "training difficulties" for one of their raters. I would suggest that, upon closer examination, the problems described as "reliability" concerns may well be linked to cultural issues (Wig et al. 1987a). Another important factor to consider for the Indian study is that patients in the Indian sample were recruited at the time of first contact with psychiatric services. This recruitment criterion makes the study not entirely comparable with the previously completed EE studies cited above. As is widely acknowledged, first-admission patients may have a better prognosis than patients with multiple admissions.

THE CAUSAL CONUNDRUM

Having argued for the reciprocal contribution of expressed emotion and psychological anthropology to the problem of social response to mental disorder, I wish briefly to consider the pragmatic implication of the principal finding of EE researchers—that it is "predictive" of clinical relapse. To be considered valuable by re-

searchers in this paradigm, the relationship between high EE and relapse must be found in the absence of "confounding" variables. Rather than commend this stance, I take it to represent a failure to be minimally concerned with the specification of context (such as gender, household size, and social class). The predictive value of EE, like any statistical analysis, is limited and must be confined to discussions of large group differences. It tells us nothing about how given individuals might intend their communications or how these might be interpreted by persons to whom they are directed.

The issues involving the complexity of contexts and individual response have been passed over, unfortunately, and some investigators and mental health professionals have made the interpretive leap that, because EE is statistically associated with exacerbation of symptoms, it "causes" relapse (see reviews of this pitfall by Koenigsberg and Handley 1986). This simplistic line of reasoning has been particularly distressing to mental health advocate groups, who feel that such an interpretation blames families for "causing" and "maintaining" the illness. While there are clear disclaimers in the EE literature about this connection (e.g., Brown et al. 1972), the issue has received insufficient attention. Hatfield et al. (1987) have outlined specific concerns about the uses and abuses of EE research as interpreted in clinical practice. They point to the problem that may occur when data analytic strategies (cutoff points for designations of "low" and "high" EE) become reified into "either-or" distinctions. Low EE may come to be equated with "good" families and high EE may be negatively associated with "bad" families. Another implicit assumption to which these authors appear to object is the idea that high-EE relatives have a "personality" problem and should take a lesson from their low-EE counterparts.

The debate over "who-done-it" or "good guys and bad guys when things go wrong" is at the heart of the politics of EE. This is unfortunate, since polarizing discourse that appears to blame families ignores their strengths in coping with difficult family members. It ignores the possibility that some so-called "high" (e.g., critical) relatives believe that exhortations can inspire rather than harm an inactive or ill person. It ignores the fact that some of these relatives may be acting on the ethnopsychological assumption as formulated by Hatfield et al. (1987:223) that "high *unexpressed* emotion may lead to psychosomatic illnesses on the part of families or more indirect

expressions or irritation at the patient" (emphasis in original). It ignores the fact that many families are willing and interested to take a reflective, nonjudgmental view of ways to change behaviors that might be distressing to their ill relative (Mintz, Liberman, Miklowitz, and Mintz 1987; Richardson and Richardson 1985). It also ignores many American families' view that they do not want to be left "holding the bag" for failed community psychiatric aftercare and residential programs.[28]

CONCLUDING REMARKS

The goal I stated at the outset of this paper was to formulate an approach to cultural variation in social response to mental disorder based on an interactive conception of emotional atmosphere as outlined by Sullivan, Sapir, and Bateson. The main contribution of the expressed emotion paradigm to this goal is to identify criticism and emotional overinvolvement as key domains. It examines these domains with methodological rigor, empirical reliability, richness of narrative data, and a grounding in observation of everyday behavior that recognizes, as did Sullivan, a continuum between the conventional and the disturbed. An additional strength of this method is its recognition that the kind of emotional material sought is not likely to be in the overt content of the interview. Given the sensitivity of such material and the power of unconscious processes, it is assumed, instead, that emotional orientation may more likely be communicated through intended and unintended vocal characteristics of speech, such as tone of voice during the narration of events (see Beeman 1985). Seen from an anthropological perspective on the embodiment of affect, the method exhibits sensitivity to speech as a verbal gesture with immanent cultural meaning, as against a notion of speech as a representation of thought. Such a view assumes that we employ articulatory and acoustic styles as one of the possible uses of our bodies (Merleau-Ponty 1962; Csordas 1990; Frank 1986). It thus takes a step beyond disembodied, cognitive approaches that tend to neglect corporeal modes of emotional expression and communication, although it neglects other such modes as, for example, facial expressions and postures.[29] Despite its concern with emotional atmosphere, however, expressed emotion must be developed further to be truly interactive in the sense called for by Sullivan, Sapir, and Bateson.[30] Herein lies the complementary contribution of

anthropology: to specify cultural conditions of emotional force based on variations in self and its boundaries, emotional experience, behavioral rules, and conceptions of mental disorder.

Although the expressed emotion data from Spanish-speaking Mexican-descent, English-speaking British, and Anglo-American families vary from one another in cultural form and frequency, the basic components of criticism and emotional overinvolvement are equally recognizable in all three groups. That striking cross-cultural variations in social response can be observed within North America invites psychocultural analysis of other indigenous interpretations of schizophrenic illness in ways that take these domains into account. In other words, even if anthropologists are not inclined to apply the methods of expressed emotion, per se, they would do well to learn from EE studies the value of developing what I have called an anthropology of criticism and an anthropology of emotional boundaries, especially since these affective domains have been identified as important to the course and outcome of major psychiatric disorder. Anthropologists, with their fingers to the pulse of the full range of human cultures, are also well positioned to take the further step of identifying other affective domains that might be of culture-specific or broader cross-cultural relevance.

I have argued for a synthesis of expressed emotion research and psychocultural analysis of the reciprocal effects of family attitudes and illness behaviors. My interpretation of criticism and emotional overinvolvement, the principal components of the expressed emotion construct, is linked to cultural understandings of rules for appropriate behavior, intimacy, and affective distance in the context of kin relations. I have argued that social response construed in this way necessarily involves cultural variations in the construction of selves and emotion. Rather than a conception of feeling as emerging from either the intrapsychic constitution of individuals or symbolic strategies for managing social interaction, expressed emotion mediates between intrapsychic and social symbolic processes. To the extent that selves, self-esteem, persons, and identity are dynamically constituted through the formative influence of kin interaction, social response to mental disorder does vary, and we must be concerned with how that variation may be important to the course of illness.

NOTES

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[1]At the family level of analysis, my principal focus in this paper, social response includes kin attitudes and actions toward relatives with schizophrenic illness and, especially, modes of interaction with the afflicted person, such as avoidance, tolerance, ridicule, punishment, or protection (Edgerton 1969). For an overview of the key cross-cultural issues at the family level of analysis, see Lefley (1987).

[2]My use of the term "schizophrenic illness" is based on a methodological choice, or operationalization. Both the clinical status of current diagnostic criteria for schizophrenia and the ontological question of whether as a disease "entity" it is a culturally peculiar, Western historical construction continue to be the subject of debate (Kennedy 1974; Barrett 1988). The present work adopts this diagnostic construct on the grounds that schizophrenia, operationally defined, provides the methodological consistency necessary for comparative analysis. The diagnostic instrument employed in the Mexican-descent study was the Present State Examination (PSE), developed for cross-cultural use by the World Health Organization's (WHO 1979) International Pilot Study of Schizophrenia (IPSS). It is probably adequate to the task of identifying similar disorders within the heterogeneous class of schizophrenia. However, some authors (e.g., Kleinman 1988) have argued that the symptom inclusion criteria for the PSE may be too stringent and therefore overlook some of the other equally important manifestations of the illness (see Kleinman 1988).

[3]These now-famous findings provide strong evidence of cross-cultural differences in prognosis of schizophrenic illness. Though hampered by methodological problems, including a failure to record sociocultural data and an associated poverty of theoretical interpretation concerning their principal findings, the work of the WHO takes an important step toward examining many of the pressing cross-cultural research issues that remain essential to defining the course of schizophrenia, including "[q]uestions of variations in frequency, in quality of symptomatology, and in reversibility of the affliction" (Kennedy 1974:1145). Edgerton (1980) has noted that the WHO findings of better prognosis in non-Western settings may not reflect especially salutary conditions there but, instead, noxious features of industrialized

countries. Estroff (1981) has documented a complex of unsatisfactory means of subsistence or minimal participation in the wage economy, negative self-identification processes, and stigma that converge to engender, if not ensure, chronic courses for major mental illness of many American psychiatric patients.

[4]This etiological focus, which has been summarized as the "schizophrenogenic" research tradition (see Fromm-Reichman 1948), can be roundly criticized on several grounds. First, because the relevant data (disturbed family factors) are retrospective rather than prospective, an etiological assertion for the significance of disturbed family relations may be more a matter of pronouncement than of empirical demonstration. Second, unlike measures of emotional overinvolvement, the parameters of the key concepts in the family psychopathology literature were often diffuse and tended to be applied without precision. Third, hypotheses of the so-called "schizophrenogenic" mother are properly critiqued on feminist grounds, since they assume a disproportionately noxious influence exercised by mothers (also see Scheper-Hughes 1979 on this point). Attributions of blame for the illness were attributions of inadequacies in the fulfillment of the maternal role. Finally, the dominance of biogenetic paradigms in contemporary psychiatric research has presented a significant challenge to family theorists.

[5]LeVine (1990) has recently taken a step in this direction by introducing the psychoanalyst Heinz Hartmann's concept of "average expectable environment" to an anthropological audience, though, again, the emphasis appears to be on a communicative environment with emotional components rather than an emotional environment determined by expression. As such lines of interpersonal research develop, one necessary task will be to assess the methodological significance of relative emphases on cognitive or affective and behavioral or experiential orientations. Social psychologist Kenneth Gergen, writing in the same volume as LeVine, calls for a move "toward refiguring emotional terms (along with the actions indexed by those terms) as components of more extended relational patterns," with a view of relational space constituted by emotion as social performance (Gergen 1990:594). Beeman (1985) suggests that Bateson's approach to metacommunicative behavior could fruitfully be applied to the study of depression, where aside from work by family therapists very little research on interaction processes is being carried out.

[6]The relationship between expressed emotion and clinical outcome in these studies has been found to be independent of research criteria of clinical severity, including number of hospitalizations, length of illness, severity of symptomatology, and disturbed or highly aggressive behavior (as defined by Brown et al. 1972). These analyses are important because they run counter to Murphy's (1982:70) claim, cited at the beginning of this paper, that social response and attitudes toward mental disorder are directly related to the severity of disturbance.

[7]The interview itself generally runs about two hours, and subsequent analysis of the interview through use of the rating scales takes six to eight hours (Brown et al. 1978). Along with other interviewers for the present study, I was trained in a two-week workshop led by highly experienced CFI interviewers (C. Vaughn and K. Snyder), followed by several months of extensive reliability checks through co-ratings of 25 Anglo-American and British training interviews. The interviewers achieved high inter-rater reliability scores (above Pearson R of .85) with the original ratings. To maintain reliability, periodic co-ratings of randomly selected research tapes were carried out throughout the study.

[8]I use the generic term "Anglo-American" in preference to the more cumbersome and problematic "Euro-American" and "Caucasian American" to refer to the linguistic homogeneity of the sample rather than to imply any ethnic homogeneity.

[9]Brown's discussion of this problem is elaborated in an article on the prediction of clinical outcomes in relation to "life events" (Brown 1974).

[10]Fieldwork for the longitudinal Mexican-descent outcome study (including the one-year pilot study) was completed over the course of six years. For the total of 70 patients who participated, 109 key relatives were identified on the basis of reports of which adult family members had the most face-to-face contact with the patient. In some cases two such relatives were identified, whereas in others only one relative had regular close contact (defined as 35 hours or greater) with the patient. Patients resided in parental (70%), sibling (10%), and marital (10%) households. The vast majority (94%) of the families were of lower socioeconomic status, and most (65%) were monolingual or primarily Spanish-speakers (24%). Patients were recruited to the study at the time of their inpatient hospitalization for an acute psychotic episode. Fifty-seven percent of the sample was male, and the mean patient age was 26.1 (7.2). The mean number of hospitalizations was 3.3 (2.7) and the mean number of years since the time of onset (defined as the time of initial onset of psychotic symptoms) was 4.5 (3.6). The mean length of illness, calculated from the time of onset of psychotic symptoms, was 4.5 years.

[11]All of the families were of bilateral Mexican descent. Most relatives (71%) and patients (63%) considered themselves to be Mexicanos, but others who were born in the United States identify with the term "Mexican-American." My use of "Mexican-descent" is intended to subsume both terms, but occasionally I use both of these near-synonyms. The families did not identify themselves as Chicano, a term that they avoided because of its association with a particular form of political action, and which refers primarily to people born in the United States.

[12]Methods of the study included administration of the Present State Examination (for diagnosis of schizophrenia) and Brief Psychiatric Rating Scale to patients by clinicians. Social-psychiatric histories were also obtained from patients. Relatives were interviewed using the Camberwell Family Interview, an ethnopsychiatric interview, household-demographic survey, and acculturation interview (Cuellar, Harris, and Jasso 1980). This latter interview was designed to assess cultural diversity among the Mexican-descent population based on ethnic identity, language use, and cultural participation. Also collected were ethnographic observations of family interactions and activities in the patient's home and neighborhood. With the exception of the initial diagnosis interviews (conducted in the hospital), all other procedures were completed in the home.

[13]Two Spanish translations of the CFI were made by native Spanish-speakers. These were then integrated, resulting in a "semifinal" version that was administered to a group of 22 Spanish-speaking Mexican-descent relatives of patients diagnosed with schizophrenia. The final version was further adapted for colloquial usage among the Mexican-descent population in southern California (Karno et al. 1987). The adaptation of the EE scales is discussed below.

[14]Although Brown focused his interest on all three components of the expressed emotion construct, repeated studies indicate that only high degrees of criticism and/or emotional overinvolvement (and not hostility) have proven empirically to be associated with course and outcome in the British, Anglo-American, and Mexican-American studies. Therefore, as a subsidiary factor, hostility is not highlighted here. Nevertheless, results for the Mexican-American ratings of hostility are introduced below as part of a discussion of unique findings for the hostility factor from the East Indian study of expressed emotion. Even though a clear relationship has not been established between hostility (and other "expressed emotion" scales of warmth and positive remarks) and schizophrenic outcome, these data are nonetheless empirically interesting. They are also, unfortunately, beyond the scope of this essay.

[15]The cutoff points for determination of "high" versus "low" EE were empirically derived in relation to schizophrenic outcome (Vaughn and Leff 1976; Vaughn et al. 1984): a rating of six or more critical comments and/or a score of 4–5 on the scale for emotional overinvolvement. In the Mexican-descent study, we had assumed that if we found this correlation, it would probably occur at different cutoff points than for the English-speaking groups. Surprisingly, the cutoff points for Mexican-Americans were identical, suggesting that although

cultural content and styles of criticism and EOI varied considerably, the quantitative threshold for the experience of negative affect by persons with schizophrenia in these studies may be similar.

[16]The coding of the critical comments followed an inductive strategy. A complete listing of all verbatim critical comments was made for each relative. From these specific criticisms, two separate listings were made for each ethnic group. This sorting process indicated that categories of critical comments do vary by culture, some having their parallels in each language, some not. Following this process, comments were recorded into ten broader categories. The most common categories for Mexican-descent relatives were: behaviors identified by family members as disruptive/disrespectful; inactivity/unemployment; illness/symptom behaviors; strange/deviant behaviors; improper health habits; and objectionable personality traits.

[17]At the family level of analysis, criticism may be directly (and indirectly) expressed toward kin. At a community level of analysis, an anthropology of criticism would prominently take into account several other common means of expressing critical or hostile affects (e.g., gossip). Although the "expressed emotion" method discussed here concerns detailed analysis of linguistic and paralinguistic communicative channels, a thoroughgoing account of what I have called "an anthropology of criticism" would also take into account nonverbal communications and symbolic actions that likewise communicate critical or hostile affect.

[18]These eleven relatives correspond to ten patients, since two key relatives were rated high on EOI in one family.

[19]Jenkins (1988b) has more fully described this indigenously defined condition.

[20]For example, within the Mexican-descent sample of 109 relatives, only 24 (or 22%) were considered high on criticism. Of the eleven (11%) relatives who were rated high on EOI, four were also rated highly critical. One such case is the father of Gabriella.

[21]The following opening statement by a high-EOI mother is illustrative of the dynamic:

> Alejandro and I have always gotten along well because we are very *afinados* ["in tune" with one another]. In nearly all situations we don't even need to speak because we already know what the other is thinking. This is because we are exactly the same, in all things in life. It's very normal.

[22]I distinguish here between ethnopsychology as the explicit indigenous theory corresponding to our own notion of psychology, and cultural psychology in the sense developed by Shweder (1990) to denote the actual psychological processes and dynamics observable in a people.

[23]As Scarry has said, interrogation and the infliction of pain, two basic features of torture, are both language-destroying and, hence, destructive of the three principal loci of human meaning: world, self, and voice (1985:30). An understanding of the human meaning of trauma and terror as they affect refugees from political violence invariably involves an analysis of embodied events for the self (Jenkins 1990a; 1990b:4–5). See Jenkins (1991) for an account of how such events must further be understood within the context of the state construction of affect and what I call a political ethos. The state construction of affect as an essential topic of research has recently been highlighted by Mary-Jo Delvecchio Good and Byron Good (1988) in their formulation of the state transformation of emotional discourse in Iranian society.

[24]Throughout the Mexican-descent research project, the anthropological convention was observed in treating the presence and definition of "illness" or "a problem" in open-ended fashion without imposing the psychiatric term "schizophrenia." It was thus left to informants, themselves, to introduce referents such as "illness" or "schizophrenia."

[25]In this regard, Estroff (1989) has made a distinction between "I am" versus "I have" illnesses.

[26]The "household" rating for expressed emotion combines scores for criticism and emotional overinvolvement. Only one relative need be rated "high" (six or more criticisms and/

or 4–5 on the EOI scale) to yield an overall "high" household score. The rationale behind this scoring system is that one high-EE relative may significantly influence the emotional atmosphere. The cross-cultural comparisons between Mexican-descent, British, and Anglo-American households revealed the following statistical associations: (1) Anglo-American versus British Yates corrected $\chi^2 = 5.84$, $df\,1, p < .02$; Mexican-American versus British Yates corrected $\chi^2 = .530$, NS; Anglo-American versus Mexican-descent Yates corrected $\chi^2 = 7.92$, $df\,1, p < .01$.

[27]Thus far, social class has been neglected in the EE literature.

[28]That this view is not universally shared by other ethnic groups within U.S. society is a point I have established above.

[29]The neglect of vocal aspects of affective speech may stem, in part, from the difficulty anthropologists sometimes encounter in mastering non-Western languages within the relatively brief language-learning tour of duty, typically one to two years. As Keesing (1989) recently pointed out, this fieldwork canon in anthropology may not be adequate to provide data for our current theoretical interest in the interrelations of selves and emotions.

[30]This is particularly so in assessing patient-relative interactive styles. Brown (1985) reports that the method's greater focus on relatives, rather than patients, was in part an artifact of the degree of difficulty frequently encountered in interviewing persons who are either actively psychotic or only recently recovered from an acute schizophrenic episode. While patients were interviewed whenever possible, their reticence or inability to talk freely and at length led Brown to seek out relatives as more forthcoming and less vulnerable informants (Brown 1985). Despite these difficulties, currently there are both naturalistic and laboratory studies under way designed to obtain more directly interactive data.

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