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Author
Jenkins, Janis H

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CONCEPTIONS OF SCHIZOPHRENIA AS A PROBLEM OF NERVES: A CROSS-CULTURAL COMPARISON OF MEXICAN-AMERICANS AND ANGLO-AMERICANS

JANIS H. JENKINS
Department of Social Medicine and Health Policy, Harvard Medical School, 25 Shattuck Street, Boston, MA 02115, U.S.A.

Abstract—This paper explores indigenous conceptions of psychosis within family settings. The cultural categories *nervios* and 'nerves', as applied by Mexican-American and Anglo-American relatives to family members diagnosed with schizophrenia, are examined. While Mexican-Americans tended to consider *nervios* an appropriate interpretation of the problem, Anglo-Americans explicitly dismissed the parallel English term 'nerves'. Anglo-American relatives were likely to consider the problem as 'mental' in nature, often with specific reference to psychiatric diagnostic labels such as 'schizophrenia'. Although variations in conceptions appear related to both ethnicity and socioeconomic status, significant cultural differences were observed independent of socioeconomic status. These results raise questions concerning contemporary anthropological views that psychosis is conceptualized in substantially similar ways cross-culturally, and underscore the need for more contextualized understanding of the meaning and application of indigeneous concepts of mental disorder. The paper concludes with a discussion of psychocultural meanings associated with ethnopsychiatric labels for schizophrenia and their importance for the social and moral status of patients and their kin.

Key words—culture and mental disorder, schizophrenia, *nervios* and 'nerves', Mexican-American and Anglo-American families

INTRODUCTION

This paper addresses two major issues current in the ethnopsychiatric literature on folk interpretations of nerves and mental illness: (1) Recent reports on nerves [1–8] suggest that it is a concept that would not apply to major mental disorder. Interview materials reported upon here, however, document *nervios* as a notion of significant relevance for schizophrenic illness within Mexican-American families [9]. (2) The ethnopsychiatric literature suggests that severe mental illness is similarly conceived and labeled across cultures [10–12]. Through comparison of Mexican-Americans and Anglo-Americans in southern California, we demonstrate that major mental disorder (utilizing comparably diagnosed cases of schizophrenia) is not conceptualized or labeled in substantially similar ways.

(1) Illness complaints associated with nerves are commonplace across a variety of culturally distinct settings. They have been reported in Newfoundland [1], Eastern Kentucky [2], Costa Rica [3, 4], among Greeks in Canada [5], Guatemala [6], and among Puerto Ricans in the Northeastern United States [7, 8]. In a recent review article, Low [6] cites many of the foregoing ethnographic cases and others from Iran, Italy, Ireland, and Mexico to document nerves as a quasi-medical illness label particularly common to "the Western world or the Galenic medical tradition" that "should occur anywhere that Western biomedicine is present" [6, pp. 194–195]. The particular meanings conveyed through this idiom are, however, culturally specific [6]. Problems associated with nerves may communicate distress in the context of difficult or oppressive life circumstances such as family conflict, poverty, hazardous means of subsistence, marginal social status, social inequality, or lack of social support.

Symptoms commonly associated with nerves include a host of psychophysiological problems (e.g. trembling, headache, sleeping and eating disorders, dizziness, stomach ailments) and dysphoric emotions (e.g. fear, worry, anxiety, and anger). Moreover, complaints about nerves range in degree of severity: some problems stemming from nerves are considered to be mundane and entail only minor complaints [1], whereas others appear to be moderately serious [7]. The literature documenting symptoms and severity of nerves suggests that this cultural category would not likely include severe psychiatric illnesses characterized by symtomatology such as psychotic hallucinations and delusions. However, we have previously reported the use of the term *nervios* by Mexican-Americans to characterize the problem of family members diagnosed with schizophrenia [9]. This suggests that it might be useful to explore the outer reaches of folk concepts of nerves as applied to extremely severe and serious psychiatric conditions.

(2) Much of the literature suggests "that major mental disorder is viewed in substantially similar ways cross-culturally, and that the degree of similarity in conceptions of mental disorder across cultures increases with the severity of the disorder" [10, p. 72]. Folk conceptualizations of psychiatric illness typically involve particular constellations of deviant and socially disruptive behavior that are widely construed by the community to be indicative of psychosis [11–13]. Insofar as these symptom profiles are relatively invariant and are labeled with indigenous illness terms, the literature presumes that they are essentially similar to those of schizophrenic disorders.

Commonality of symptom profiles, however, is not adequate for conclusions concerning fundamental cross-cultural similarity of folk conceptions of major mental disorder. This is so because folk concepts of psychosis embody several orders of cultural knowledge concerning illness and personhood. Illness labels incorporate a variety of beliefs about the nature, causes, course, treatment, and valuation of disorder. Meanings associated with indigenous labels for psychiatric disorder have important symbolic implications for the social and moral status of persons who suffer such conditions and their families [14–16]. Identifying a problem in a less stigmatizing way, as one of 'nerves' rather than as some form of 'mental illness', for example, may differentially allow for the continued incorporation of the ill person within social groups. Variations in cultural usage of illness categories may involve not only differing degrees of stigma, but also different attributions of personal responsibility. Thus, the difficulties families face in understanding and labeling a relative's illness are made problematic not only by variations and fluctuations of symptomatology, but also by their desire to adopt the most socially acceptable and least stigmatizing of culturally available labels for the problem [14]. These notions and processes are, of course, not only of social consequence, but also of psychological importance insofar as they shape individuals' notions of self and others' degree of identification with the ill individual. Psychocultural differences in attitudes toward and conceptions of psychiatric disorder may also influence the course and outcome of illness by mediating social support and decrement to self-esteem [17–19]. Thus, even though similar constellations of symptoms may be labeled similarly as severe forms of disorder, their implications for patients' and families' life experience may be substantially different across cultures.

BACKGROUND

This paper compares the use of the term nerves and *nervios* by Anglo-Americans and Mexican-Americans to refer to the schizophrenic illness of a family member. The data reported upon here were collected as part of two larger longitudinal studies of the course and outcome of schizophrenia among Mexican-Americans and Anglo-Americans. These parallel studies employed the same procedures to investigate the influence of family 'expressed emotion' (measured through such negative affects as criticism and hostility) on the course of illness for patients returning to live at home following psychiatric hospitalization for an acute psychotic episode [20, 21]. Fuller descriptions of the background, methods, and findings of the Mexican-American [22–24] and Anglo-American studies [25] have been provided elsewhere.

Patients in both of these southern California studies had been hospitalized in local in-patient psychiatric facilities for an acute psychotic episode. Project inclusion criteria required that research staff psychologists diagnose patients as suffering from schizophrenia according to the Present State Examination. The research diagnosticians of the Mexican-American study were bilingual Hispanic psychologists. All patients in the Mexican-American sample also met DSM-III criteria for schizophrenic disorders, whereas only 63% of the Anglo-Americans were similarly classified. Over one-third (37%) of the

Table 1. Sociodemographic characteristics of Mexican-American and Anglo-American patients*

	Mexican-Americans ($N = 40$)		Anglo-Americans ($N = 27$)	
	N	%	N	%
Sex				
Female	16	40.0	6	22.2
Male	24	60.0	21	77.8
Mean age (SD)	26.9 (7.8)		21.6 (3.2)	
Marital status				
Married	7	17.5	1	3.7
Single	29	72.5	25	92.6
Separated	3	7.5	1	3.7
Divorced	1	2.5	0	0.0
Religion				
Catholic	34	85.0	10	40.0
Protestant	1	2.5	10	40.0
Apostolic	3	7.5	0	0.0
Other	2	5.0	5	20.0
Mean years of education (SD)	8.7 (3.9)		11.6 (1.2)	
Socioeconomic status (Hollingshead & Redlich)				
I	0	0.0	3	11.1
II	0	0.0	5	18.5
III	1	2.5	9	33.3
IV	18	45.0	8	29.6
V	21	52.5	2	7.4
Family type				
Parental	28	70.0	25	92.6
Sibling	5	12.5	1	3.7
Marital	7	17.5	1	3.7
Mean household size (SD)	6.2 (3.2)		3.6 (1.4)	

*Due to rounding error, percentages do not necessarily total 100%. Also, for the Anglo-American sample, there were two cases of missing data for patients' religion.

Table 2. Selected clinical characteristics of patients*

	Mexican-Americans (N = 40)		Anglo-Americans (N = 27)	
	N	%	N	%
Mean length of illness (SD) (in years)	5.17 (4.00)		1.23 (1.37)	
Mean number of hospitalizations (SD)	3.3 (2.5)		1.6 (1.2)	
Recent medication				
No	31	77.5	19	76.0
Yes	9	22.5	6	24.0

*Due to rounding error, percentages do not necessarily total 100%. Also, for the Anglo-American sample, some of these data were unavailable.

Anglo-American patients received diagnoses of schizophreniform disorders. (Diagnoses of schizophreniform disorder are made when all diagnostic criteria for schizophrenia are met except for the duration of illness. The illness must last more than 2 weeks but less than 6 months.)

Patients were between the ages of 18 and 55 and living with parent, spouse, or other close relative(s) prior to and following hospitalization. Patients in the Mexican-American study were of bilateral Mexican descent, whereas patients in the Anglo-American study were non-Hispanic, English-speaking Caucasians. Other than ethnicity, the only major difference in the criteria for selection in these two projects was length of illness. In the Anglo-American study, the onset of psychotic symptomatology must have occurred no more than 2 years prior to the time of entry into the study. In the Mexican-American project, length of illness was not a criterion for patient inclusion. Socioeconomic status was not a recruitment criterion for either the Mexican-American or Anglo-American study.

THE STUDY

Sample

As part of these major studies, sub-samples of key relatives who maintained frequent, day-to-day contact with patients were interviewed to ascertain their ethnopsychiatric (or folk) interpretations of the illness, i.e. what they believed to be the nature of the problem, its cause, presumed course, and preferred treatment. Sixty-one relatives of the first 40 patients who entered into the Mexican-American study were interviewed, as were 47 relatives of 27 patients from among the latter half of the cohort of the Anglo-American study, which had commenced after the Mexican-American project.

Sociodemographic and clinical characteristics of the samples are presented in Tables 1–3. Only the more noteworthy factors will be mentioned here. As a group, the Anglo-American patients were younger and included all levels of socioeconomic status; however, the Mexican-American patients were of lower socioeconomic status and tended to reside in rela-

Table 3. Sociodemographic characteristics of relatives*

	Mexican-Americans (N = 61)		Anglo-Americans (N = 47)	
	N	%	N	%
Sex				
Female	36	59.0	26	55.3
Male	25	41.0	21	44.7
Mean age (SD)	46.0 (14.9)		49.2 (9.8)	
Marital status				
Married	38	62.3	30	63.8
Single	11	18.0	0	0.0
Separated	2	3.3	0	0.0
Widowed	5	8.2	0	0.0
Divorced	5	8.2	14	29.8
Living with significant other	0	0.0	3	6.4
Relationship to patient				
Mother	26	42.6	24	51.1
Father	14	23.0	17	36.2
Sibling	13	21.3	3	6.4
Spouse	7	11.5	1	2.1
Other	1	1.6	2	4.3
Socioeconomic status				
I	0	0.0	6	12.8
II	0	0.0	11	23.4
III	2	3.3	14	29.8
IV	29	47.5	13	27.7
V	30	49.2	3	6.4

*Due to rounding error, percentages do not necessarily total 100%.

tively larger households. Reflecting the differing criteria for patient inclusion in the studies, the Anglo-American patient group had been ill for a shorter length of time (calculated from time of first psychotic symptoms) than had the Mexican-Americans; moreover, the mean number of hospitalizations was less for the Anglo-American sample. According to the Cuellar scale for acculturation [26], the Mexican-American sample was considered relatively unacculturated. Although most of the families had lived in the United States for over 10 years, the majority of the patients (70%) and relatives (71%) were first-generation immigrant *Mexicanos*. Two-thirds (67%) of the relatives interviewed were primarily or exclusively Spanish-speaking. The possible influence of the foregoing factors upon the results obtained will be the subject of later discussion.

Procedures

Relatives were interviewed in their homes. The interviewers for the Mexican-American sub-sample (the author and 3 Hispanic research associates) were fluent in both Spanish and English, and the interview was conducted in whichever language the respondent seemed most comfortable. In the vast majority of cases this was Spanish. Interviews were taperecorded, but answers were also manually recorded during the interview.

This report focuses upon relatives' responses to the following open-ended questions asked during the interview: What kind of problem is it? Do you think it could be a problem of nerves/*nervios*, mental illness, or something else? How would you describe a problem of nerves/*nervios?* Did a doctor speak to you concerning the nature of the problem? And, if so, were you or another family member given a report (diagnosis) concerning the problem? All categories that relatives considered to be appropriate were recorded, as was the open-ended response 'something else'.

Terms such as 'illness', 'nerves', 'mental disorder', 'schizophrenia', and the like, were never used by the interviewers in the open-ended questions. Rather, it was clearly conveyed that the interest was in understanding the conceptions held by family members about 'the problem'. The responses given vary in the degree of specificity and detail. Also, in response to the question about the nature of the problem, some relatives mentioned more than one problem (e.g. nerves and mental illness). In such cases, their responses were multiply coded to reflect all responses mentioned by relatives.

RESULTS

Conceptions of the problem

In response to the open-ended question, a variety of categories was used to characterize the problem. For the Mexican-American relatives, however, *nervios* was the most common term for the problem (36%). Without explicit use of the term, several others (12%) cited specific behaviors or problems typically associated with *nervios*. Thus, 48% of the Mexican-Americans relatives conceptualized the problem as one of *nervios*. (Specific behaviors associated with *nervios* and the various other Mexican-American response categories have been fully discussed elsewhere [9], and will be only briefly summarized below as part of the discussion on the nature of nerves/*nervios*.)

The majority of the Anglo-American relatives responded to the question, "What kind of problem is it?", with a specific term referring to a psychiatric disorder such as schizophrenia, psychosis, or depression (55%) or characterized the problem as being associated with mind or brain (34%). Thus, the vast majority (89%) of Anglo-Americans included mention of some type of mental or psychiatric disorder, while almost half of the Mexican-Americans (48%) considered it to be a problem associated with *nervios*. There was only one specific mention of nerves by an Anglo-American. The nature and meaning of this isolated response is completely non-comparable with those given by the Mexican-Americans. Mexican-American notions of *nervios* involve an understanding of the problem as beyond the control of the individual [9], a non-Hispanic view of the problem as one of nerves incorporates core Anglo-American cultural values of individual initiative and personal control:

He had an "I-don't-give-a-damn" type of deal... "I don't care any more." Sick, but he also plays sick. I think that he still is sick. I think he has the kind of sickness where if you

Table 4. Mexican-American and Anglo-American relatives conceptions of problem as nerves/*nervios*, mental illness, or 'other' categories

	Mexican-Americans ($N = 61$)		Anglo-Americans ($N = 47$)	
	N	%	N	%
NERVES/*NERVIOS*				
No	20	32.8	42	89.4
Yes	41	67.2	5	10.6
Totals	61	100.0	47	100.0
	($\chi^2 = 34.75$; $df = 1$; $P = 0.000$)			
MENTAL ILLNESS				
No	45	73.8	15	31.9
Yes	16	26.2	32	68.1
Totals	61	100.0	47	100.0
	($\chi^2 = 18.84$; $df = 1$; $P = 0.000$)			
OTHER				
No	44	72.1	29	61.7
Yes	17	27.9	18	38.3
Totals	61	100.0	47	100.0
	($\chi^2 = 1.32$; $df = 1$; not significant)			

Table 5. Multiple conceptions of the problem held by Mexican-American and Anglo-American relatives

	Mexican-Americans ($N = 61$)		Anglo-Americans ($N = 47$)	
	N	%	N	%
Nerves only	29	47.5	2	4.3
Nerves and mental illness	5	8.2	2	4.3
Nerves and other	7	11.5	0	0.0
Mental illness only	10	16.4	25	53.2
Mental illness and other	1	1.6	4	8.5
Other only	9	14.8	13	27.7
Nerves, mental illness, and other	0	0.0	1	2.1
Totals ($\chi^2 = 39.43$, $df = 5$, $P = 0.000$)	61	100.0	47	100.1*

*Due to rounding error, percentages do not necessarily total 100%.

don't bother him and you let him do what he wants then he's fine. Once you start laying out reality to him, that's when the sickness occurs. I don't think he's psychotic or schizophrenic. I've worked with them, and he's not like that. I think it was the situation. I think he had the problem of nerves, but they all kick in when he wants them to kick in. I think he controls them.

In addition, there were three mentions by Anglo-Americans of 'nervous breakdown', but the infrequency of this response suggests that this once popular folk and medical term is falling into desuetude. The response of the mother of one patient reported the transition in her own thinking: "I used the term 'nervous breakdown' for a time before I realized that mental illness was the situation." Other mentions of the term 'nervous breakdown' and 'nervous reaction' indicate that, unlike biomedical terms which often focus upon neurochemical bases of disease, problems associated with nerves more often incorporate psychosocial etiologies. The following examples illustrate this point: "We felt guilty that we may have pushed her too far, over the edge, to a nervous breakdown." "[The problem is] not being able to handle the stresses and disappointments which causes him to have a nervous reaction."

Analyses of responses to the follow-up 'forced choice' question "Do you think it could be a problem of nerves/*nervios*, mental illness, or something else?" are presented in Tables 4 and 5. Table 4 illustrates the individual categories and the statistical differences in the response pattern of Mexican-Americans and Anglo-Americans. As can be noted, striking differences exist between the two groups: the majority (67%) of Mexican-Americans considered the problem to be one of *nervios*, whereas only a minority (11%) of Anglo-Americans thought it might be a problem of nerves.

To account for this finding, the relative effects of ethnicity and socioeconomic status (SES) must be examined. Logistic regression analyses revealed that both ethnicity ($\chi^2 = 9.47$; $P = 0.002$) and social class ($\chi^2 = 5.99$; $P = 0.014$) were highly significant in relatives' conceptions of the problem as one of nerves/*nervios*. However, sub-group analyses of all lower SES relatives (classes IV and V) revealed significant ethnic differences between Mexican-Americans and Anglo-Americans both within class IV ($\chi^2 = 5.46$; $P = 0.02$) and class V ($\chi^2 = 8.46$; $P = 0.004$). Thus, when these separate analyses were undertaken, the ethnicity effect remained significant within the lower social class groups.

While the majority (68%) of the Anglo-Americans affirmed that mental illness was the problem, only about one-quarter (26%) of Mexican-Americans viewed the problem similarly. For this item, ethnicity alone seemed to account for the differences ($\chi^2 = 6.94$; $P = 0.008$); social class differences proved non-significant.

The ethnic and social class differences were statistically insignificant for the open-ended 'other' category. However, the content of these miscellaneous responses revealed differences in the sorts of things which Mexican-Americans and Anglo-Americans considered problematic. For the Mexican-Americans, this category was comprised of assorted problems including: physiological problems, witchcraft, personality problems ('overly amibitious', 'stubborn'), 'destiny', trauma, drugs, family problems, or the current absence of any problem. For the Anglo-Americans, the content of responses in this category included: personality deficits (laziness, immaturity), stress, drugs, inactivity, or the current absence of any problem.

The fact that the Mexican-Americans mention *nervios* more often in the 'forced choice' item than in the open-ended response may be related to the cultural appeal this category holds once it has been introduced. It may be that relatives overcame an initial suppression of what they regarded as a culturally appropriate term for the illness. Similarly, the Anglo-Americans may be somewhat more likely to choose the open-ended 'other' category when it is offered since it affords them an opportunity to give their views concerning other things they consider problematic. In addition, while it was possible for respondents to cite more than one kind of problem, the vast majority of both the Anglo-Americans (85%) and Mexican-Americans (79%) are likely to consider only one kind of problem. Table 5 illustrates the various patterns or combinations of relatives' problem conceptions.

Descriptions of nerves/nervios

When relatives were asked to describe a problem of *nervios*/nerves there were again both similarities and differences in the responses given by the Mexican-Americans and Anglo-Americans. The Mexican-American descriptions of *nervios* have been discussed

at length elsewhere [9], and will only be briefly summarized here. *Nervios* is generally considered to afflict weak or vulnerable persons. While there are a number of different types of *nervios* described, two major types were mentioned most often. The first is one in which a person is easily angered or often irritable. The second is characterized by symptoms such as tension, anxiety, worry, agitation, feelings of insecurity, fear, frustration, and desperation. Less commonly mentioned troubles associated with *nervios* included: sadness, depression, or feeling dispirited, somatic effects (e.g. dizziness, feeling pain in the brain or neck), and confusion.

Anglo-American descriptions of a problem of nerves were obtained for a sub-set (over one-half) of the total sample of 47 relatives. Several relatives declined to give descriptions of nerves, stating they did not really know or that they did not understand why they were being asked such a question because it bore no relevance to their relative's condition. In several cases in which relatives were quite adamant about the presence of a schizophrenic disorder and conveyed they were interested in responding only to questions that applied to their relative, the question was not asked for fear of losing the rapport necessary for the successful completion of the interview. In other words, for many of the Anglo-American relatives, questions concerning a problem of nerves 'fell on deaf ears', insofar as they asserted they either had little or no conception of the term or considered it inapplicable or tangential to their own views of the nature of their relative's problem.

Aside from this major difference in response pattern, Anglo-Americans were similar to Mexican-Americans in sharing the two most common descriptions of nerves. In the first, the person is said to be prone to emotional outbursts and to be frequently irritable. Such a person is said to be short-tempered, easily upset, 'touchy', likely to 'fly off the handle', and possibly aggressive. And, like Mexican-Americans, the Anglo-Americans were equally likely to describe a problem of nerves as one of being highly anxious, fearful, worried, insecure, jittery, 'on edge', 'uptight', or tense.

However, other descriptions of nerves varied. Anglo-Americans were twice as likely as Mexican-Americans to describe a problem of nerves as an inability to cope or function. Some respondents emphasized that the trouble a nervous person has is, for example, 'getting on top of the situation' or 'being able to cope with what's on hand or whatever comes up'. Another ethnic difference in the responses offered was that Mexican-Americans were more likely to describe a problem of *nervios* as one in which the person felt sad or suffered from certain somatic symptoms (e.g. dizziness, back pain). In contrast, Anglo-Americans were somewhat more likely to mention fear as part of a problem of nerves. Finally, several Anglo-American relatives made a point of saying that what they were describing was not their relative's problem.

Physician diagnosis and folk conceptions of illness

It might be expected that physician diagnostic findings would be a significant source of influence upon family members' conceptions of and terms for the illness. This issue was investigated by analysis of responses to the question: "Did a doctor speak to you concerning the nature of the problem, and, if so, were you (or another family member) given a report

Table 6. Have you ever received a physician's/therapists's report concerning the nature of the problem?

	Mexican-Americans ($N = 61$)		Anglo-Americans ($N = 47$)	
	N	%	N	%
No physician/therapist contact	8	13.1	5	10.6
Physician/therapist contact but no diagnosis statement ever given	17	27.9	7	14.9
Yes, diagnosis was given*	36	59.0	35	74.5
Totals	61	100.0	47	100.0
	[$\chi^2 = 3.11$, $P = 0.2$ (n.s.)]			

*Relatives report physician/therapist said problem was:

	Mexican-Americans ($N = 36$)		Anglo-Americans ($N = 35$)	
	N	%	N	%
Schizophrenia	12	33.3	32	91.3
Nerves	8	22.2	0	0.0
Stress/illness	0	0.0	1	2.9
Mental	6	16.7	0	0.0
Biochemical imbalance	3	8.3	1	2.9
Epilepsy	2	5.6	0	0.0
Head injury	1	2.8	0	0.0
Nervous breakdown	0	0.0	1	2.9
Miscellaneous**	4	11.1	0	0.0
Totals	36	100.0	35	100.0
	($\chi^2 = 25.98$; $P = 0.000$) (Computed for 3 groups: schizophrenia; nerves; and all other responses)			

**This category includes relatives' reports of physicians' statements of patients' need to 'open up/communicate', 'mature', and 'be distracted'.

(diagnosis) concerning the problem?" The analyses of responses to this question are presented in Table 6. As can be seen, more Anglo-Americans reported having received physician diagnoses than did Mexican-Americans. This may seem somewhat surprising in light of the fact that the Mexican-American patients had been hospitalized more often and ill significantly longer than were Anglo-Americans. It is likely that the relatively lesser salience of physicians' diagnoses for the Mexican-American families is related to several factors, including language barriers, limited availability of physician consultation time for low income families, and a lack of physician–family rapport stemming from cultural differences.

Even more striking, however, are the major differences in the nature of physicians' diagnoses as reported by relatives. While nearly all of the Anglo-Americans reported a diagnosis of schizophrenia (in one case, psychosis), only one-third of the Mexican-Americans did so. Many of the Anglo-American relatives reported that they were not aware that a specific psychiatric diagnosis, i.e. schizophrenia, was appropriate for their relatives until they were so informed by a doctor. The other diagnoses listed in Table 6 reported by relatives are non-comparable, particularly the *nervios* category mentioned by 22% of the Mexican-American relatives but absent among Anglo-Americans. It is conceivable that this non-comparability may have arisen from physicians' belief in a necessity to simplify diagnostic findings for the Mexican-American relatives.

An analysis was conducted of the degree of agreement between relatives' prior open-ended statements of the problem and their reports of physician diagnoses. The criterion for congruity in conception of the problem was that relatives gave the same category of response, e.g. relative's conception of patient's problem as a 'mental illness' and physician's diagnosis of schizophrenia. For the Mexican-American relatives who received diagnostic reports (59%), overall general agreement between physicians and family members was 47%. The comparable figure for Anglo-Americans was 63%.

In only two cases (3%) were Mexican-American relatives' responses in explicit agreement with a doctor's diagnostic report of schizophrenia. Moreover, these instances need to be qualified in the context of the larger Mexican-American sample. In one case, the respondent was relatively acculturated, English-speaking, and college educated. In the other instance, the father's characterization of the problem as 'schizophrenia' must be understood as influenced by a physician, as the father stated: "The *doctors* say it's incurable, that it's schizophrenia." In addition, the father stated that his son's problem also involved *nervios*. Thus, the term schizophrenia, like 'mental illness' generally, has limited currency among Mexican-Americans, even if relatives have been informed of such a diagnosis.

The relatively greater agreement between Anglo-American relatives' conceptions of the problem and what they reported they were told by physicians suggests either that they may have been influenced to some extent by physicians' diagnoses, or that their own folk models of illness are more generally congruent with the medical model. The lesser degree of agreement between Mexican-Americans' conceptions of the problem and reported physicians' diagnoses suggests that they may be less likely to be influenced by medical opinion. The case for a relative lack of congruence between Mexican-American folk and medical models may be equally as strong as that for a tendency to be less influenced by physician statements. When there is congruence between Mexican-American and medical conceptions of the problem, there is a much higher rate of agreement: while there was lack of agreement for all but 2 of the 12 relatives given a diagnosis of schizophrenia, there were only 2 disagreements in the 8 instances where relatives reported being told that the problem was one of 'nerves'. These disagreements, moreover, like the 2 agreements with diagnoses of schizophrenia, may reflect unique circumstances. In one case, the relative had previously stated that there was currently no problem; in the other, the relative had stated the problem involved witchcraft, and hence was much more serious than *nervios*.

The interesting finding that 22% of the Mexican-Americans (and none of the Anglo-Americans) reported that they had been given the diagnosis of 'nerves' raises the possibility that some relatives did not accurately remember or report physicians' findings, or that their reports were colored by their own views of the nature of the illness. One relative went so far as to cite an X-ray report that had 'shown twisted nerves', thereby clinically documenting the problem as one of *nervios*.

DISCUSSION

The finding that cultural categories of nerves are often considered appropriate for schizophrenic disorders by Mexican-Americans but are not similarly applied by Anglo-Americans requires several lines of explanation. As we have seen, the latter group displayed a marked preference for psychiatric and mental illness terms. We turn our attention now to a discussion of clinical, sociodemographic, and cultural factors that might account for differences in family conceptions of and labels for schizophrenic illness.

It will be recalled that the samples did not differ on ethnicity alone. First, the Mexican-American patients had been hospitalized more often and had been ill longer than their Anglo-American counterparts. Thus, the Mexican-American relatives had had significantly more time living with a disturbed family member and reflecting upon what the nature of the problem might be. As discussed elsewhere [9], unacculturated Mexican-Americans often conceive of a developmental sequence for cases of *nervios*, which, if severe enough and chronic, may develop into mental illness. Therefore, what may have initially been conceptualized as a problem of *nervios* might later be considered mental illness. However, for the majority of relatives in the present study this developmental sequence seems not to apply, since no differences could be detected in the relationship between length of patient illness or number of hospitalizations and relatives' conceptions of the problem as *nervios* (in contrast to mental illness). Consistent use of the term *nervios* by Mexican-American families despite the

relatively longer periods of illness would seem to attest to its resilience as a folk category.

There were also major socioeconomic status (SES) differences between these 2 samples: nearly all of the Mexican-American relatives were of lower status whereas the Anglo-Americans were broadly distributed across the various status levels. As presented in the statistical analyses reported above, the differences in conceptions of the problem as nerves/*nervios* are related to *both* cultural and social class factors. However, as demonstrated through sub-group analyses, ethnic differences were also found independent of social class. This finding suggests the strength of cultural factors in mediating relatives' conceptions of illness.

There is further evidence that the findings of this study are not primarily due to differences in socioeconomic status (SES). In both the open-ended and the 'forced choice' questions, the majority of the Anglo-American relatives considered the problem to be one of mental or psychiatric illness. This statement holds true for relatives from all SES levels. Of the 5 persons who did think the problem involved nerves, 2 were upper middle class and 3 were lower middle class. It might also be speculated that differential use of the term schizophrenia was affected by social class. However, Anglo-American reports of 'schizophrenia' were also representatively distributed across levels of socioeconomic status, and were not confined to the upper and upper middle classes. One note of qualification is in order, however. None of the 3 Anglo-Americans in the lowest SES group (class V) employed the term, offering some support for the notion that schizophrenia is not a term employed by persons of little formal education and low income.

As we have also seen, variations in folk conceptions of the 2 groups appear to be related to differing degrees of influence by or congruence with the diagnosis reported to families. It appears that many of the Anglo-American conceptions of the problem are highly medicalized, i.e. specifically reflective of a biomedical nosology of disease. These relatives are not only more likely to have received a physician's diagnosis but also to have access to many sources of English-language popular media which provide medical information. Thus for the Anglo-Americans there is a more extensive feedback relationship between the professional theory of illness and disease and informal or folk systems. Over time the professional discourse becomes conventionalized in lay sectors [16, p. 139]. Indeed, many of the Anglo-Americans' views of the problem were phrased in specifically clinical terms (e.g. "a disease, a full-blown schizophrenia with paranoid overtones").

It should be noted that these observations record a historical change and dynamic integration in Anglo-American concepts of mental disorder. In preceding decades both folk and medical usage of the terms 'nerves' and 'nervous breakdown' were more in currency. The Anglo-Americans' rejection of 'nerves' as the problem and reticence to provide descriptions in terms of 'nerves' attest to its perception as increasingly outdated. In fact, within the American medical community today there is a notable lack of psychiatric publications with titles such as the *Journal of Nervous and Mental Disorders*, which commenced publication in 1874. As Kleinman [27, p. 177] has documented, the nature of what diagnosis holds the most 'social and cultural cachet' varies historically and cross-culturally. In China, for instance, medical diagnoses of 'neuroasthenia' (nervous exhaustion) are still extremely common [27], whereas they have virtually vanished in North America in the 20th century.

A possible lure for Anglo-American adoption of the term schizophrenia stems from contemporary etiological implications of the term. It is exceedingly common in clinical settings for professionals to introduce schizophrenia to families by explaining it as 'a biochemical imbalance'. In addition to providing a name for an elusive and baffling condition, such information is often intended and received as guilt-allaying, helping to put to rest relatives' frequently pernicious fears that they may have in fact 'caused' their son or daughter's condition. This folk view is historically rooted in decades of etiological research which sought to establish the family as 'schizophrenogenic' by inducing or producing schizophrenic illness [28, 29]. Notions of the problem that quell such fears would seem to augur well for their popular appeal. This point applies with equal force to the patients. Such disease concepts ideally absolve the individual from personal responsibility. It is analogous to contemporary professional attempts to modify folk notions of alcoholism and eating disorders by casting them as diseases rather than deficits in moral character.

Such attitudes are complex, and not infrequently, fraught with ambivalence. It is important to recall, for example, that Anglo-American views of the problem also incorporate other troubles such as personality deficits (e.g. laziness). These may be regarded as the sole problem or considered in tandem with a mental/psychiatric condition. Disease may well be present, these relatives may concede, but they concurrently feel that certain negative personality traits are present as well. The perception that undesirable personality traits are involved is related to core American values such as responsibility, autonomy, independence, and initiative [30, 31]. Disease attributions within the American cultural context do not necessarily confer a diminished capacity for personal action. Rather, core values and cultural notions of the person are retained even in the presence of a major mental disorder, for they constitute the capacity to muster the proper 'fight' against a psychiatric condition.

Mexican-American retention of the folk category *nervios* is not surprising, for reasons comparable to those that render notions of *psychiatric disorder* appropriate for Anglo-Americans. Not only is there less communication of professional opinion, but there is also a lack of similar medical information available via the Spanish-language media. Given the lack of comparable sets of medical influences upon the Mexican-Americans, relatives rely on their own cultural knowledge to label and conceptualize their family member's illness. *Nervios* is a broad-ranging category that can encompass family perceptions of schizophrenia. Mexican-American notions of mental illness are often too extreme for families to consider them appropriate for their relatives. The reason given for eschewing such labels is often that ill family

members are perceived as experiencing a range of both normal and abnormal states not characteristic of someone who is 'truly crazy'. It is also generally true that notions of *nervios* do not generally incorporate an attribution of blame for the family. This lack of personal responsibility for illness processes has been reported among Mexicans by Foster [32]. This is in notable contrast to Anglo-American views of the moral importance of personal responsibility in turning a tide of unfortunate events to one's favor, attitudes which are centrally reflected in views of illness.

An intriguing finding of the present study was the similarity in symptom descriptions of nerves/*nervios* for both ethnic groups; however, the application of this term revealed striking cultural variations. On the one hand, the similarity of descriptions provides evidence for some commonality in folk medical traditions, as well as in the biological and psychophysiological bases of 'nerves' that are manifested in symptom behaviors. On the other hand, the remarkable lack of common application of folk categories for nerves stems from a host of culturally distinctive factors.

As has been discussed, the ethnic differences in folk labels for schizophrenia are not explicable by length of illness, number of hospitalizations, socioeconomic status, or variations in physician diagnostic consultation. These factors are insufficient to account for the notable differences in folk conceptions. Rather, it seems that folk categories of nerves and *nervios* possess culturally distinctive meanings for Mexican-American and Anglo-American families. As we have seen, Anglo-Americans are in strong accord that nerves is not the problem afflicting their family member. Their orientation to the problem is shaped by clinical emphasis on symptom profiles which determine the appropriate illness category.

Nervios refers to a wide and diverse range of emotional states and illness phenomena. However, as noted earlier, Mexican-American folk application of *nervios* to schizophrenic disorder is not mediated by symptom criteria alone. *Nervios* is broadly applied for persons who are distressed over difficult life circumstances. In contrast to Anglo-American notions of nerves, a central element in Mexican-American definitions of *nervios* is the individual's loss of control in the face of difficult life circumstances [9].

Also essential to the understanding of the cultural meaning of the use of the term *nervios* for schizophrenic illness is the overwhelming importance of family bonds in Mexican-American culture. Family identity is central to the Mexican-American individual [33–35]. Relatives' attempts to identify with the ill family member may induce them to adopt the culturally acceptable illness term of *nervios* in order to maintain the strong self-other connections within the family context. Many of the Mexican-American relatives mentioned that they too had suffered from *nervios*—albeit in a milder form—and therefore had some understanding of their relative's illness. In this way, conception of the illness as *nervios* enables the maintenance of close identification of family members by fostering the view that the relative is "just like us, only more so" [36].

A closely related point concerns the nature of affective bonds within family contexts. Mexican-American family bonds are ideally characterized by enduring affection. Relative to the Anglo-Americans reported upon here, emotions expressed by Mexican-American relatives were more often characterized by warmth and acceptance. In contrast, the Anglo-Americans displayed significantly more criticism and hostility toward their disturbed family member. This finding is complex and merits in-depth discussion beyond the scope of the present report [22]. It is important, however, to bear this difference in mind. Such affective attitudes may induce Mexican-Americans to take what they consider to be a milder, more empathetic interpretation of the illness than do the Anglo-American relatives. We consider this difference in emotional orientations to ill family members to partially tone conceptions of psychiatric disorder. The cross-cultural differences in responses were evident, for example, in the relatives' interview responses. Mexican-American views embody emotions of sadness, pity, and at times, an aura of tragedy. Their descriptions of *nervios* were more likely to focus upon sad affects and dysphoric emotions than those of the Anglo-American group. Their style of interpreting the problem more easily allows for the expression of anguished and tender feelings toward the ill person, as well as a desire to protect and shelter her/him. In contrast, Anglo-Americans are relatively more likely to be matter-of-fact or vitriolic in their descriptions of the illness.

Certainly other psychological and social forces serve to shape folk conceptions of schizophrenia. It cannot be doubted that psychological defense mechanisms such as denial are at work to ward off the conception and label of mental illness. This may largely be due to the social stigma associated with extremely severe or chronic mental disorders such as schizophrenia. Hispanic families will go to great lengths to avoid adopting the such labels [9, 37]. The relative willingness of the Anglo-Americans to entertain these labels must be understood against the backdrop of professional attempts to de-stigmatize schizophrenia by virtue of a scientific approach to it as a biochemical deficit. The Mexican-Americans are far less likely to be privy to this biomedical information. The fact that Mexican-Americans are more often concerned with differing emotions and social-relational features associated with illness makes *nervios* a plausible category for this severe disorder. These latter two points highlight folk categories as not entirely determined by symptom profiles but rather by the social relations, moral standing, and emotional well-being of the person [38–40].

CONCLUSION

In this paper, two major arguments have been presented. (1) *Nervios* serves as a culturally salient interpretation for schizophrenic illness within Mexican-American families. This finding calls into question the ethnographic view that *nervios* applies only to non-psychotic conditions. (2) There are substantial ethnic and social class differences in conceptualizations of severe mental disorder. This conclusion calls into question prevailing universalist views

of the cross-cultural similarity of folk categories for schizophrenia.

These critiques are based on a study of systematically diagnosed cases for schizophrenia analyzed within particular *family* contexts. This degree of contextualization of illness experience has seldom been available in previous studies of conceptualizations of mental disorder. It might be objected, however, that conclusions regarding cross-cultural similarity of cultural knowledge concerning mental disorder are valid at a community or societal level of analysis. Indeed, strong evidence exists to document similarity of conceptions of psychosis across differing cultural communities [11, 12, 41]. While we may expect a cultural continuity between family and community response, close kin may interpret mental disorder somewhat differently than other, non-kin cultural members [13, 42]. Such variations in social response may partly be due to family members' first-hand familiarity with particular illness episodes. For example, use of *nervios* for schizophrenia might be accounted for in part by relatives' experience of periodic ameliorations in severity of illness, which induces them to consider the condition milder than is connoted by 'mental illness'. Such family interpretations are also constructed to adopt the least stigmatizing of labels.

While there are, then, differences between general societal conceptions of mental disorder and those which close kin entertain, the family data presented here for specific schizophrenic illness episodes do nonetheless raise questions concerning prevailing anthropological and psychiatric views of major disorder as conceptualized in substantially similar ways [12]. As we have seen, the Mexican-American and Anglo-American relatives did not share similar conceptions of or labels for schizophrenic illness within their families. The striking variations between Anglo-Americans and Mexican-Americans within one geographic locale serve as a critique of universalist conclusions concerning the cross-cultural commonality of folk conceptions of psychosis.

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