Shifting Blame Away From Ill Relatives

Latino Families' Reactions to Schizophrenia

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Abstract: The present study examined attributions, emotions, and help-giving of 24 relatively unacculturated Latino-Americans toward a family member with schizophrenia. Ninety-one percent of participants had been rated as low in expressed emotion (low-EE) in an earlier study using a sample that overlaps with the present study. Low-EE refers to relatives who express few critical attitudes when talking about a mentally ill family member. Study findings indicate a link between relatives' emotions and their reported help-giving behavior. In support of attribution-affect theory, relatives who reported feeling more compassion toward an ill family member also reported exerting more effort to help their relative cope with the illness. A qualitative analysis of relatives' views, values, and behaviors was also conducted with the aim of better understanding low-EE relatives' perceptions, which may serve to buffer schizophrenia relapse. We observed the following three main categories of attributions: (1) most participants accepted the patient as having a legitimate illness, (2) the majority of participants viewed interpersonal problems or other external environmental stressors as causing or exacerbating the disorder, and (3) many participants implicated God in their causal attributions and also reported turning to religion as a source of hope and comfort in coming to terms with the patient's illness. Together, the quantitative and qualitative data suggest that efforts to augment positive or favorable emotions in key family members may be most important in establishing a low-EE family environment.

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A family member's illness (*i.e.*, schizophrenia) undoubtedly has an emotional impact on the ill person's closest relatives. A large body of research indicates that relatives' negative emotional responses, particularly the construct referred to as expressed emotion (EE), are highly predictive of a poor course of illness (reviewed in Butzlaff and Hooley, 1998; Kavanagh, 1992). After being discharged from a hospital, patients with schizophrenia who return to family environments reflecting hostile, critical, or emotionally overinvolved attitudes (high-EE) have been found to have a poorer course of illness than those patients who return to low-EE homes in which relatives do not hold as many of these negative attitudes (*e.g.*,Brown et al., 1972; Vaughn and Leff, 1976). In fact, patients who return home to live with relatives designated as high-EE are approximately twice as likely to relapse than are those patients who return to low-EE homes (Bebbington and Kuipers, 1994; Kavanagh, 1992). Expressed emotion among relatives has been found to be a strong predictor of relapse in patients with schizophrenia in the United States across different ethnic groups (*e.g.*, Karno et al., 1987; Vaughn et al., 1982) and in many other countries (*e.g.*, Brown et al., 1972; Ivanovíc et al., 1994).

Several studies in the past decade offer support for an attribution-affect model developed by Weiner (1980), which suggests that people's attributions toward the actions of another person are related to the emotional responses that they have toward that person. Hooley (1985) was the first to suggest that an attributional model may apply to relatives' reactions to schizophrenia. In the past decade, a number of studies have tested an attributional model of EE and have found that relatives' level of expressed emotion is related to their attributions of control. In other words, high-EE relatives perceive patients as able to control certain aspects (symptoms) of their illness more than do low-EE relatives (Barrowclough et al., 1994; Brewin et al., 1991; Weisman et al., 1993; 1998; 2000).

Other studies have also revealed that family members' attributions of controllability are related to specific emotional reactions. For example, investigators have found that attributions of control are related to more criticism (*e.g.*, López et al., 1999) and hostility (*e.g.*, Brewin et al., 1991) and less warmth (*e.g.*, Barrowclough et al., 1994). In addition, two studies have found that controllability attributions are related to patient relapse. Barrowclough et al. (1994) provided evidence for a direct attribution-relapse pathway, whereas López et al. (1999) found that attributions and criticism jointly

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predicted clinical outcome. Together, these studies provide support for an attribution-affect model of relapse. (We are not implying that attributions cause or lead to EE. Nor do we mean to imply the opposite, that EE leads to particular attributions of key relatives. The actual relationship between attributions and EE is likely to be complex and has yet to be discerned.)

To date, no investigations have examined a third aspect of the attributional model, the interrelation of attribution, affect, and help-giving offered by the relatives. Drawing on Weiner's attribution theory (1986; 1995), López and Wolkenstein (1990) took the attributional perspective a step further and hypothesized that greater controllability attributions may lead high-EE relatives to feel anger and annoyance toward patients and therefore offer them little in the way of help or support. In contrast, low-EE relatives may view the illness as outside of the patient's volitional control, may feel sympathy or pity, and in turn may be more tolerant, helpful, and supportive.

Controllability attributions are related not only to relatives' EE, specific emotional reactions, and patients' relapse, but also to patients' specific symptoms of schizophrenia. Schizophrenia is a mental disorder characterized by serious disturbances in thought processes, emotions, and social interaction (American Psychiatric Association, 1994). These disturbances fall into two categories: positive symptoms and negative symptoms. The first group refers to florid symptoms and behavioral excesses such as delusions, hallucinations, and disorganized speech. The second group is composed of negative symptoms, which are behavioral deficits such as flat affect, lack of motivation (avolition), and social withdrawal. Leff (1994) observed that most critical comments seem to target the negative symptoms of schizophrenia and suggested that this may be a result of relatives' viewing such symptoms as personality characteristics (being lazy or selfish). Weisman et al. (1998) confirmed that negative symptoms are more often criticized than positive symptoms in schizophrenia. In addition, these investigators found that protests about positive symptoms were rare. They interpret their findings as suggesting that because positive symptoms are so unusual, they may be more easily recognized as a core part of the illness of schizophrenia. Negative symptoms, however, are more subtle and exist to some degree in a variety of disorders (*e.g.*, dysthymia); thus, they may be less readily identified as part of a serious illness, and therefore may be more prone to criticism.

One limitation of expressed emotion research and the application of attribution theory to this line of inquiry is that investigators have focused on what about high EE predicts relapse. Recently, some researchers have called for greater attention to what families do that may buffer relapse (López et al., 1999). The cross-cultural literature of the course of schizophrenia may be particularly helpful in beginning to identify the prosocial family factors associated with a more positive course of illness. Although the EE construct has been found to predict relapse cross-culturally, with populations from Europe (*e.g.*, England, France, Denmark), North America (*e.g.*, whites, African-Americans, Mexican-Americans), Asia (*e.g.*, Taiwan and India), North Africa (*e.g.*, Egypt), and Australia (Jenkins, 1991), studies have observed that low EE is prominent in less industrialized or more traditional cultures (reviewed in Kavanagh, 1992; Weisman, 1997; critique, Edgerton and Cohen, 1994). (Although there is no widely accepted definition of the term *traditional cultures*, in this article, we use the term to indicate societies that are collectivistic and tradition-oriented.) The study of Latino families may be useful in examining what about traditional cultures may be associated with better outcomes. For example, Guarnaccia et al. (1992) and Jenkins (1991) point out that Latinos frequently refer to schizophrenia as *nervios*, which has both a physical and a mental connotation. Guarnaccia et al. (1992) define *nervios* as "a symptom and syndrome for expressing psychological distress, somatic discomfort, and problems in the social sphere" (p 208). The authors explain that schizophrenia is viewed on a continuum that ranges from being nervous (*estar nerviosa),* to suffering from nerves (*padecer de los nervios*) or enduring stress, to a state of psychological distress (*perturbación mental*), to the losing touch with reality with little hope of recovery (*locura*). Jenkins (1991) also points out that *nervios* are generally considered to be beyond a person's control and worthy of sympathy and special treatment—and are therefore not blameworthy—and rarely, if ever, reduce the person to an illness-identity. Thus, Jenkins (1991) and Guarnaccia et al. (1992) believe that conceptualizing the illness in this way actually helps the family cope with the possibility that their relative may "slip into madness" (Guarnaccia et al., 1991, p 209). This line of inquiry suggests that how schizophrenia is construed may be central to a family environment that buffers relapse.

GOALS AND HYPOTHESES

In an attempt to understand potential buffers to schizophrenia relapse better, the present study brings together two lines of inquiry: the attributional basis of families' expressed emotion, and how Latino families construe schizophrenia. Specifically, we have chosen to study the attributions, emotional reactions, and help-giving offered by a sample of primarily low-EE, relatively unacculturated Latino relatives of patients with schizophrenia. We apply both a quantitative and a qualitative (descriptive) approach to identify how these relatives understand and conceptualize the illness, and how they react emotionally and try to help their ill family member.

In this study, we tested three sets of hypotheses pertaining to relatives' attributions of control, emotions, and help-giving behavior toward a patient with schizophrenia. Although the literature suggests that Latinos may be less likely to hold relatives with schizophrenia as responsible for their illness, data by Weisman et al. (1993) suggest that even

among Latinos, those who attributed more control to their loved one also expressed relatively more negative emotions (*i.e.*, anger) than did those relatives who attributed less control to their relatives. Stemming from this observation and from Weiner's attribution theory (1980), we tested the hypothesis that relatives who view the patient's illness as more under the patient's personal control would express more unfavorable emotions and fewer favorable emotions toward the patient. In an effort to examine help-giving, we also examined the interrelations among relatives' attributions of control, emotional reactions, and reported help-giving. We expected that greater controllability attributions and greater unfavorable affective reactions would be associated with less help-giving. Finally, stemming from attribution theory and from previous findings by Weisman et al. (1998), it was further hypothesized that negative symptoms of schizophrenia would elicit greater perceptions of control, greater unfavorable emotions, and less willingness to help patients get better than would positive symptoms.

METHODS

Participants

Our sample consisted of 24 relatives (18 female and six male) who were recruited through their participation in a larger treatment study (Telles et al., 1995). Participants were primarily monolingual Spanish-speakers of relatives of persons with schizophrenia residing in Los Angeles, California. The sample was also relatively unacculturated as designated by Cuellar's acculturation scale (1980). All participants were of Mexican, Guatemalan, or Salvadoran descent, and 91% had been previously designated as low-EE in the study by Telles et al. (1995). Patients (nine female and 15 male) were referred from local psychiatric facilities and ranged in age from 18 to 55 years old. All patients had been living in the community with a relative for 6 months before admission and met criteria for schizophrenia based on the administration of the Present State Examination (Wing et al., 1974) and DSM-III-R (American Psychiatric Association, 1987). All interviews were conducted in Spanish.

Procedure

Relatives were interviewed either in their home or in a local mental health center responsible for their ill family member's care. The interviews were conducted at different phases of the families' participation in the parent study: some were conducted during the treatment phase, whereas others were conducted during follow-up. At the beginning of the interview, relatives were first asked to speak freely for 5 minutes describing their ill family member and how they got along with the family member.

Relatives were then asked a set of structured questions about their family members' specific symptoms. The survey had an equal number of questions specifically targeting positive symptoms (hallucinations and delusions) and negative symptoms (poor concentration and anhedonia). Relatives were first asked whether a specific symptom had occurred since the patient's first contact with a hospital or a mental health center. If the relatives answered affirmatively, the interviewer began inquiring about attributions of that specific symptom. If the respondent said no, then the interviewer asked about the second symptom. Attribution ratings for positive and negative symptoms were assessed by averaging the responses to three questions using three identical separate 3-point Likert scales (1 = not at all, 2 = a little, 3 = a lot). The questions concerned the relatives' perception of the cause of the symptom. They were first questioned about what they thought the cause of the symptom was and whether they thought their ill relative was responsible for (*responsable*), could control (*controlar*), and was to blame for (*tenia la culpa*) for this cause. Cronbach's alpha for the controllability scale was .40 for positive symptoms and .85 for negative symptoms.

Relatives were asked in an open-ended question what emotions they felt toward the ill family member when the family member was exhibiting certain symptoms. After the open-ended probe, the relatives were asked to rate on a 3-point rating scale (1 = not at all, 2 = a little, 3 = a lot) the extent to which they felt a set of emotions. These emotions were categorized as either favorable or unfavorable. Compassion (*compasión*), pity (*lástima*), and sadness (*tristeza*) were categorized as favorable emotions in this survey following the classification of earlier researchers, because they are thought to reflect empathy and other positive sentiments towards the patient (Weisman et al., 1993). A total favorable emotion score toward positive and negative symptoms was created by averaging the means across the three questions that inquired about favorable feelings toward patients exhibiting these symptoms. Cronbach's alpha for the favorable emotion scale was .85 for positive symptoms and .93 for negative symptoms. Unfavorable emotions for positive and negative symptoms were similarly assessed by averaging the means of three rating scales regarding feeling angry (*enojo*), mad (*coraje*), and bothered (*molestia*) at their ill family members. Cronbach's alpha for the unfavorable emotions scale was .87 for positive symptoms and .96 for negative symptoms.

Last, relatives were asked what kind of help they provided their ill family members when they exhibited the symptom or illness. Using 3-point Likert scale with ratings identical to those described (1= not at all, 2 = a little, 3 = a lot), relatives were asked the degree to which they would like to help and how much they actually tried to help their ill family member when the family member was exhibiting positive and negative symptoms. Cronbach's alpha for the help-giving scale was .83 for positive symptoms and .75 for negative symptoms.

RESULTS

Tests of Specific Hypotheses

A series of Pearson *r* correlation coefficients were conducted to test the attributional model (analyses were conducted separately for positive and negative symptoms). Results indicated that the model was partially supported for negative symptoms. Compassionate or favorable emotions (mean, 2.38; SD, .79) were associated with a greater desire to help the patient get better (mean, 2.67; SD, .50; $r = .82$; $p < 0.01$). However, contrary to expectations, controllability attributions for negative symptoms (mean, 1.39; SD, .49) were unrelated to both favorable ($r = –.09$) and unfavorable emotions (mean, 1.61; SD, .67; $r = .06$) and to help-giving behavior ($r = –.17$ for negative symptoms). Also contrary to expectations, no relationships were found among controllability attributions (mean, 1.32; SD, .35) and favorable emotions (mean, 2.57; SD, .65; $r = .07$), unfavorable emotions (mean, 2.78; SD, .62; $r = –.08$), or help-giving behavior for positive symptoms ($p > .05$ for all).

Two *t*-tests were conducted to assess the hypothesis that negative symptoms, compared with positive symptoms, would elicit greater controllability attributions and more intense unfavorable emotional reactions toward a mentally ill relative. Results were not significant for attributions ($t = .35$; $p > 0.05$) or for unfavorable emotional reactions ($t = –.72$; $p > 0.05$). In other words, negative symptoms were neither perceived as more controllable nor associated with more unfavorable emotions than were positive symptoms.

Qualitative Summary

The content analyses reported in this section come from 20 cases for which we had verbatim transcripts from recorded interviews (in four cases, the recording was either inaudible or missing). We observed that relatives tended to target three primary areas when conceptualizing the cause of the patient's symptoms and schizophrenia-related behaviors. We categorized these three areas as (1) legitimate illness, (2) interpersonal/environmental stressors, and (3) religiosity/spirituality. (In this article, we make no distinction between the terms *religiosity* and *spirituality*. Although such a discussion is beyond the scope of this article, it should be noted that although they are related concepts, *religiosity* generally refers to a shared belief system [dogma] and communal ritual practice [liturgy], whereas *spirituality* usually refers to one's search for meaning and belonging and the core values that influence one's behavior [Sperry, 2001, p 4].) During the interview, 90% of relatives ($N = 18$) made at least one statement indicating a perception that the illness, symptoms, or both were caused by some type of illness, such as a genetic abnormality, mental disorder, or other physical factor (*e.g.*, a "malfunctioning brain"). Similarly, 90% of relatives (18 cases) perceived that interpersonal problems (*e.g.*, divorce) or other external environmental stressors (*e.g.*, work stress) were a cause or an exacerbating factor in the illness. Finally, we found that 40% of the sample ($N = 8$) made at least one reference to God or religion in discussing their relatives' illness. Nearly all of these comments reflected that participants were using religion in a supportive manner. In other words, religion and spirituality were used primarily as an aid to understand better and come to terms with the illness. Specific examples of each category are provided in the discussion.

From the interviews, we observed that relatives tended to report favorable emotions in high degrees, regardless of the symptom type. In other words, if a relative reported feeling sad when the ill family member had a hallucination, this relative also likely reported feeling sad when the ill family member was not able to concentrate. None of the participants in this study reported any current unfavorable emotion toward the ill family member for either symptom cluster. However, the majority (67%) reported having felt at least one unfavorable emotion toward the relative in the past.

DISCUSSION

A primary goal of this study was to understand better the characteristics of low-EE relatives that may mitigate the course of schizophrenia. A content analysis of the interviews indicated that most participants have a system of attributions that appear to shift blame for the illness and symptoms away from the patient. We observed three primary categories or types of attributions that were prominent in this sample. First, we found that the majority made some reference to the patient as having a legitimate illness, usually of organic origin. For example, when asked what is the principle cause of the patient's troubles, one of the relatives stated (all excerpts are translated from Spanish), "I say, that her mind is not well. She has problems in her mind. I have heard on television that people have cells in their brains that die for some circumstance, and they are never the same." When asked by the interviewer whether the relative perceived the patient as responsible for her mind not being well, the relative elaborated by saying, "No, I don't think she is to blame. Well, it's her illness. Because no one who is sick is going to be at fault for being sick."

Even for those relatives who recognized that the cause of the symptoms was a mental disorder, few referred to it as *schizophrenia*. Consistent with observations by Guarnaccia et al. (1992) and Jenkins (1991), several relatives (33%) in the present study instead referred to it as *nervios,* which translates to *nerves* and reflects a condition that is as much physical as mental, that suggests a vulnerability, and that is outside of relatives' personal control. In a study comparing experiences of caring for a mentally ill relative among different ethnic groups, Guarnaccia and Parra (1996) similarly found that a large percentage of their Hispanic sample relied

on the concept of *nervios* to make sense of the illness. Together, these independent studies provide consistent evidence of *nervios* serving as an important explanatory model (Kleinman, 1988) of serious mental illness among some Latinos. Understanding the illness from the vantage point of *nervios* may encourage more favorable and empathic responses toward mentally ill loved ones.

Despite the fact that most participants in this study viewed the root of the patient's symptoms as stemming from some form of legitimate physical or mental disorder, most also implicated interpersonal relations or uncontrollable environmental factors as playing a causal or exacerbating role. Some interpersonal examples included the stress associated with the death of a family member, broken engagements, and failed marriages. One relative said, "...This [marital separation] is one of the principle causes that has affected him very much. How do I say it? The failure of his marriage." Another parent who also attributed her daughter's illness to a recent marital breakup said that she thought the cause of her symptoms was that "she lacked love."

Other common environmental factors included the perception that behaviors such as work stress, poor diet, or excessive studying caused the problem. One relative reported believing that the primary cause of the illness was "mental exhaustion from her job. She just worked and studied. She hardly ever rested." When asked if the relative thought the patient was to blame for having the illness, the relative responded, "...Well no, too much work is to blame... Well, too much work and not eating well. She worked too much and didn't eat well. There were times when she didn't even eat breakfast." While speaking freely, another relative said, "I think this child carried too much. He was very studious and dedicated to his studies. He was always attached to his books. I think perhaps that's what it is. He carried too much in his brain. I think that's the principle reason. "

In the present study, it appears that many of the participants held a vulnerability stress model of illness. Most seemed to recognize that their loved one had an illness but believed that environmental stressors in the patient's life exacerbate the illness or set it off. This view is consistent with the diathesis stress model of schizophrenia, a model with wide empirical support (World Health Organization, 1992). Perhaps patients from more traditional cultures fare better because their relatives subscribe to more compassionate attributions about the illness. In turn, these attributions may encourage relatives to interact in more supportive, understanding ways.

In this study, we also observed that many relatives used religion to conceptualize the illness. This finding is consistent with that of Guranaccia and Parra (1996), who also found that religious perceptions shaped many minority families' conceptions of mental illness. In the current study, participants tended to use religion in a manner that offered hope and comfort and might conceivably lead to lower levels of anger and frustration toward the patient. For example, when asked what the relative perceived as the cause of the illness, one participant replied, "You know that God places these bad difficulties in many people, right? And it's hard to understand. Only God knows why, right?" Another relative, when asked if he thought his son's condition was permanent, replied, "[He] has a lot of faith that he will get better. He talks to me about it. Because I tell him right away, listen... He talks like this: 'I ask you with all my faith, all my heart for God, our Lord. Not only to deliver me. But to deliver my brothers and you.' So we, because of this faith we have in God...it's not impossible to us that he can be cured even if...even if it's permanent or if it's incurable; for God, nothing is impossible. The day God wants to and that we have faith, He will make him sane." Additional comments referring to religion included the following: "I only ask God to give us patience to bear all this. To survive what comes up, right. What can we do? It's out of our hands. So, we have to be cool and calm to get through it." Another relative said, "What I do is ask God, my God, since I was little, my parents raised me in, in an environment to have faith in everything to...trust God for everything. And that's what I say: ′My God, without you we are nothing. You're the one who has to help us. If you sentence us, you know the reasons. But you also have to help us survive them, right?'"

Excerpts from the qualitative data suggest that religiosity may be a major factor contributing to the absence of current unfavorable feelings toward patients and for the low levels of high EE observed in this and in other Latino samples (*e.g.*, Karno et al., 1987). Catholicism and other organized religions often encourage the acceptance of things one cannot control. This perspective may prepare people for life's uncertainties, and thus the acceptance of vulnerability. This perception supports the view that there is no protection against adversity and that anything that happens to anybody can happen to me. It would also seem that this perspective may impress many Latinos with the need to be more compassionate, understanding, and tolerant of other people's failures, such as mental illness. This orientation may account for, in part, the low levels of anger and hostility elicited by Latino and other families from traditional cultures when presented with schizophrenic relatives, and subsequently the lower levels of schizophrenic relapse observed in their patients (Weisman, 1997).

In this study, we also observed that the three categories of attributions that relatives frequently gave to describe their perceptions about the cause of patients' symptoms (illness, relationship/environmental stressor, and religious beliefs) also appeared to influence the manner in which they attempted to help their loved one. For example, most family members reported believing that the cause of their family member's trouble was some form of illness, often genetic or

organic in origin. Consequently, many relatives responded to a prompt about help-giving by reporting that they frequently attempted to assist patients by encouraging them to take their medication and reminding them to keep any medical or other therapy appointments. For example, when asked, "How do you try to help with your relative's illness?" One family member said, "Well, I always give her the medicine and I take her to the doctor whenever she has an appointment. I think that is the best help that I could give." Another relative replied, "The only thing I do is make her follow her treatment. I'm always telling her, 'Go to the clinic, get your injection.' This is how I help. I try to get her to go to therapy on her own and to take her injection. Of course, I always wish that she was like she was before, but I know that is not possible, because now I know that schizophrenia is for life, but if she follows her treatment well, she will be well."

With respect to the second category of common attributions (that relatives frequently implicated environmental or interpersonal factors such as poor nutrition or loneliness as a cause or antagonist of the illness), relatives frequently reported help-giving behavior that included offering food, advice, or company. For example, when asked how she helped, one relative said, "I always heat up food... I always give her special food... I make her take vitamins and I give her food."

Another relative said, "I give advice," and another stated, "I try to chat with her. For example, if I know that something has happened, I try to discuss the reasons with her. I always try to make her converse with me and then I tell jokes to make her laugh." When asked the same question about help-giving, another relative replied, "Well, the union you see, the union we have in our family, this has helped him very, very much."

With respect to the third category of commonly observed attributions, as stated, many relatives implicated God in the cause of the illness. Consequently, we also found that many participants reported relying on religion and spirituality in attempting to help their loved one manage the illness. One relative said, "We give him advice and tell him to go to church, you see? At church he gets a lot of comfort and listens to the priest." Another stated, "What I do is ask God for help, and I ask God for protection."

Findings from this study also suggest that emotions are linked to help-giving. Our results partially support applying Weiner's model (1995) for understanding reactions to severe mental illness better. With this relatively unacculturated sample of Latino-Americans, relatives who feel more compassion toward a patient exhibiting certain types of symptoms (poor attention and anhedonia) are more likely to help them cope with their illness. It is unclear why Weiner's model (1995) was not supported for positive symptoms (*i.e.*, hallucinations), nor is it clear why the results relating attributions to emotion and unfavorable emotion to help-giving behavior were not significant. It may be that our small sample size was not powerful enough to detect such relationships, should they exist. Our nonsignificant results may also have been largely affected by our unique Latino and low-EE sample. As several previous studies have indicated, low-EE relatives tend not to make controllable attributions toward their relative's illness and also hold few negative emotions toward them. Thus, our range in attributions and negative emotions may have been too restricted to observe meaningful relationships among these constructs.

Given the link between compassionate emotions toward negative symptoms and family help-giving, our results also suggest that it may be useful for clinicians to aim one component of their family intervention at increasing relatives' empathic and favorable feelings toward a loved one with schizophrenia. Perhaps one way to achieve this aim may be to educate family members directly about the fact that behavioral deficits such as emotional withdrawal or poor hygiene may not appear to be core symptoms of mental illness but are in fact integral components of schizophrenia. In the process of eliciting compassionate feelings in relatives, it may also be important to help caregivers recognize that, even for patients actively attempting to take control of their illness (by taking medications, doing skills training, and so forth), some disruptive symptoms are beyond patients' control and are apt to persist or recur despite clinical intervention and patients' best attempts to help themselves get better.

Interestingly, none of the participants in this study reported any current unfavorable emotion toward the ill family member in the present tense. However, in explaining their perspective beyond their response to specific inquiries about current symptoms, most did report having experienced unpleasant feelings toward the relative at some point since the illness began. For example, one relative said, "It used to drive me crazy until I read everything at the clinic and then understood how serious the illness was." Another relative said, "I used to get really mad until I learned that it was hereditary. Now I know that I have to help her the best I can, until I die." In part, the lack of unfavorable emotions may be a function of some of these key relatives' participation in a family treatment study to reduce emotional negativity (Telles et al., 1995). Another factor may be that for some Latinos, maintaining harmony among family and friends is highly valued (Marín and Marín (1991) for a discussion of *simpatía*). Accordingly, those that adhere to this cultural script may tend to frame attributions and emotions in a culturally sanctioned positive manner, thus contributing to the low rates of unfavorable emotions. For example, when asked whether he got upset when his family member heard voices, one participant had this to say: "Yes, I sometimes get angry, you see? But soon after I felt sorry for lecturing him and everything because he is sick." Another relative replied, "No, no. I was scared. And...and sad. Fear and sadness. I never get angry...

It takes a lot, a lot to get me upset. A whole lot... And what for. No. No, I don't get angry."

It is important to acknowledge that the limited expression of negative emotion observed in this Hispanic sample may also reflect a cultural tendency toward social desirability. In an earlier study comparing Anglo-Americans with Mexicans, Weisman and López found that Mexicans scored significantly higher on a social desirability scale than did Anglo-Americans. Furthermore, in this study, a socially desirable response bias was associated with decreased reporting of negative emotions. Findings from the study by Weisman and López (1996) in conjunction with those of the present study suggest that researchers may wish to consider the role of this response pattern, especially when examining Latinos' self-reports of the expression of unfavorable affect. However, Weisman and López (1996) caution that this is a complicated issue. A disposition toward suppressing socially undesirable thoughts and feelings may be intrinsically related to a tendency to actually suppress unfavorable sentiments toward another person (rather than reflecting a volitional underreporting of negative emotion). A reserved or socially desirable response style by relatives may have a beneficial impact on patients with schizophrenia who may have difficulty coping with the demands of intense emotional interaction. This view is consistent with the finding by Anderson et al. (1984) that high-EE relatives (based on emotional overinvolvement) were characterized by outgoing personality styles and emotional expressiveness. Thus, social desirability, or the suppression of some types of affect, may be one factor that contributes to more positive outcomes. This point warrants further investigation.

Future research with larger samples may help clarify the role that these psychosocial factors play in family members' support of mentally ill relatives. In our sample, interviews were performed at various stages of two different interventions (a behavioral family therapy and an individual case management). It is unclear, therefore, how stage and type of treatment may have impacted relatives' emotions and attributions toward the patient. Another restriction of the current study is that our sample was made up of relatively unacculturated, primarily monolingual Spanish-speaking participants. In future studies, it will be important to assess the relationship of level to acculturation to the behavior of Latino relatives. It will also be important to assess directly whether the content of family members' attributions relates to EE levels and to relapse rates. If it is found that certain types of attributions, such as those frequently observed in this study (*e.g.*, illness, environmental/interpersonal, religious), predict lower EE and better course of illness, it may be useful to develop family-oriented interventions that specifically target these beliefs.

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