1 Schizophrenia as a Paradigm Case for Understanding Fundamental Human Processes*

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> We have found in the most disorganized group of people – I believe the psychiatrist would agree that the schizophrenic is the most disorganized of the functional mental illnesses – a continuation of very much that is simply human. Harry Stack Sullivan, *Schizophrenia as a Human Process* (1962: 224).[1]

> In psychotics we see more spectacularly the process of personal affective evaluation as a common symbol . . . even the private world of meaning of a psychotic patient has its roots in culture. Edward Sapir, "The Symbol" (1933), in *The Psychology of Culture* (edited by Irvine 1994: 224).[2]

From the standpoint of an anthropology concerned with the nature and meaning of subjective experience, it would appear to be commonplace to argue that a theoretically grounded understanding of cultural orientation, self, emotion, and social relations is vital to the analysis of a complex pathological phenomenon such as schizophrenia.[3] At the same time, the study of schizophrenia illuminates the nexus between culture and fundamental human processes and capacities for experience. Although the latter idea may appear novel or undue both in an anthropology that typically bypasses schizophrenia and in a psychiatry dominated by neuroscience and psychopharmacology, in this chapter I seek to demonstrate that it is neither.[4]

My argument cuts both ways – not only does the anthropological commonplace hold for the study of schizophrenia, but schizophrenia itself offers a paradigm case for scientific understandings of culturally fundamental and ordinary processes and capacities of the self, the emotions, and social engagement.[5] This position stands in contrast to the presumption in medical and social sciences that schizophrenia is immaterial to theorizing the configuration of human experience and development because it is utterly foreign to normal experience and subversive of normal development. This is because it is thought to dislodge fundamental capacities for subjective experience. Degenerative and irreversible physiological

processes are deemed to render such persons quite unlike their "normal" counterparts, no longer having the capacity to be active within, or responsive to, culturally created worlds.[6] This is not the case (see Kring this volume).

Moreover, people who suffer from this disorder can offer insights into human processes that are fundamental to living in a world shared with others. This is the case because the construction of shared meaning, usually taken for granted, can become fraught in schizophrenia (see Corin, Good, Lucas, Estroff, Diaz, and colleagues this volume). Their attempts to create shared meanings often entail a tremendous struggle, whereas for those who do not have schizophrenia, this is so often taken for granted (see also Jenkins 1988a, 1991).

In this chapter, then, I argue that (1) the subjective experience of persons with schizophrenia is forged at the nexus of culture and agency, desire and attachment, none of which are annulled by disease process; and (2) the study of schizophrenia casts a bright light on our understanding of culture and subjectivity more generally. Thus, the "extreme case" of schizophrenia poses a challenge for the human sciences. The challenge is to specify the conditions of erosion, retention, or transformation of subjective faculties. The challenge is, furthermore, to take into consideration the complicated tangle of motive, strategy, and stance that persons inhabit not only as a consequence of, but also in spite of, their schizophrenic illness. Finally, these subjective processes figure most significantly in the mediation of the course of illness, that is, along pathways to recovery and improved functioning or sustained states of psychosis with impaired functioning.

Thus the "edge of experience" is cut in ways that are at once ordinary and extraordinary, conventional and inverted, lucid and distorted, making schizophrenia a paradigm case for the broader elucidation of fundamental human processes. In other words, in certain ways that can be specified, people afflicted with schizophrenia are just like everyone else, only more so.[7]

I wish to make clear the terms of my approach to the study of *fundamental* and *ordinary* human processes and capacities. First, in examining fundamental processes I presume the dialectical constitution of culture and psyche, intentional persons and intentional worlds, in the sense outlined by Richard Shweder (1990). This approach proceeds "without the presumption of fixity, necessity, universality, and abstract-formalism" (24). It represents a shift away from an *a priori* expectation of psychic unity based on invariant central-processing mechanisms. Instead, it conceptualizes fundamental processes in terms of domains (such as self or emotion) that are viewed, from the outset, as invariably mediated by culture and context.

The relationship between schizophrenia and fundamental processes is also usefully understood in terms of the particular perspectives or "situated standpoints" that actors adopt (Haraway 1991; Harding 1991). From such standpoints, culture can be understood as shared and patterned in some respects, while particularized, contested, and fragmented in others (Lutz and Abu-Lughod 1990). Awareness of the particularization of experience leads to a cautionary note that what is often taken to be "fundamental" about human processes may not be their universally invariant form but rather their culturally constituted form at the most basic level of organization.

Second, through examination of ordinary processes and capacities I mean to call attention, not only to the extraordinary, but also to the everyday dimensions of schizophrenic experience. This shift in attention is critical to apprehend schizophrenia in its own right and as a means for understanding ways in which subjective experience is routinized. For example, Corin (1990) shows how structured, predictable, and sometimes solitary activities such as taking a daily walk to a favored coffee shop or bus stop can be a kind of positive withdrawal that constitutes a social "stance" and "buffer" against emotional upset. Moreover, such strategies and routines appear to be critical to recovery and stabilization. In addition, the ordinariness of schizophrenia is revealed through attention to patients' most vexing personal issues, arguably little different than those of their non-afflicted counterparts: How can anyone love me? Why would I love anyone when all it means is torture? What can I do in this life? Where is my hope that relief is in sight, that my pain and suffering will end? These questions become particularly pressing for those who have experienced substantial recovery from their illness, for example, those who have responded to medication with "atypical antipsychotics" (Jenkins and Miller 2002). Examining the factors contributing to the success or failure of the afflicted in answering these questions adds to our understanding of how those same questions are addressed in more mundane lives with less complex challenges.

Conceptualizations of the normal and the abnormal are implicated in the study of both fundamental and ordinary processes. In the study of psychopathology we have yet to resolve the problem of what Georges Canguilhem (1989) defined as the ontological versus positivist conceptions of disease. Is there, as the ontological view would have it, a distinct qualitative difference between anxiety as a normal emotion and anxiety as a pathological state? Or, as the positivist view would hold, is there only one anxiety, the intensity of which can vary quantitatively from total absence to a degree that becomes so great as to be pathological? In this view, abnormality is defined as "more" of what otherwise might be considered within the bounds of normal human experience (Jenkins 1994b:104).

Canguilhem (1989:45) invokes Nietzsche to underscore that "the value of all morbid states [is] that they show us under a magnifying glass certain states that are normal – but not easily visible when normal." In this chapter, I argue that in the case of schizophrenia, strict differentiation between the normal and abnormal is not possible to sustain epistemologically or empirically.

Culture Theory, Schizophrenia, and Human Processes

As noted in the Introduction, the inception of the line of thinking I advance here took place in the 1920s at the interface of psychiatry and social science among a circle of scholars working on culture, normality, and psychopathology (Sapir 1924; Mead 1928; Lasswell 1930; Benedict 1934; Sullivan 1937; Powdermaker 1939; Bateson and Mead 1942). This interdisciplinary alliance was sparked particularly by the collaboration of psychiatrist Harry Stack Sullivan and anthropologist Edward Sapir. In an essay entitled "Cultural Anthropology and Psychiatry" that first appeared in 1932, Sapir (1932:151) theorized that the "true locus of culture is in the interactions of specific individuals and, on the subjective side, in the world of meanings which each one of these individuals may unconsciously abstract for himself from his participation in these interactions." Sapir's dynamic formulation of culture as created and recreated among persons in the process of social interaction paralleled Sullivan's (1953:10) conception of psychiatry as the study of interpersonal relations under any and all circumstances in which these relations exist. Their colleague Ruth Benedict (1934) argued for the cultural specification of such circumstances to include gender; only recently has this theoretical proviso been accorded empirical attention in studies of schizophrenia (Goldstein and Tsuang 1990; Haas, Glick, Clarkin, Spencer, and Lewis 1990; Kulkarni 1997; Lewine 1994).[8]

Sullivan (1962:12) located schizophrenia in everyday social and cultural situations and as such implied "nothing of deterioration" but rather of a "disorder in which the total experience of the individual is reorganized" especially in the domain "of thinking in complex images, to use Levy-Bruhl's excellent expression." Sullivan's point was not to pathologize everyday experience but to emphasize the continuity between the ordinary and the pathological in contrast to a too-rigid, categorical distinction between them.

For Sapir, thinking about schizophrenia was a productive route for anthropological theorizing about subjective experience. Take, for example, the concomitant requirements to orient consistently to cultural and social circumstances, on the one hand, and to protect the self from such

circumstances when potentially self-injurious, on the other. One strategy for resolving the conflict between the self and the powerful socioemotional milieu is "to blot out the external world by realizing one's weakness in the midst of strong forces" (Sapir 1994:155). Opting for the solution of "blotting out" or denying the external environment over which one has control was for Sapir, "(i)n its morbid extreme" nothing less than *dementia praecox*" (Sapir 1994:155).

Taken together, these early conceptualizations serve as forerunners of contemporary anthropological theory of lived experience (Turner 1992; Corin and Lauzon 1994; Csordas 1994a; Good 1994; Kleinman 1995). Arthur Kleinman and Joan Kleinman (1995:95–6) have identified accomplishments and challenges for the study of lived experience within the field of medical anthropology. On the one hand, the interpretive method of these studies invariably reveals illness as a socially constructed reality. On the other hand, we are faced with an "interpretive dilemma" when, having established the myriad facets of illness "as social role, social strategy, or social symbol," illness is reinscribed "*as anything but* human experience" (Kleinman and Kleinman 1995:96, emphasis added). To transcend this paradox, Kleinman and Kleinman (97) call for "experience-near" ethnographic categories that concern "processes and forms of experience," in which "something is at stake for all of us in the daily round of happenings and transactions." This proviso is critical, not only to the present analysis but also for the broader field of anthropology insofar as it is concerned with the contours of human experience.

Byron Good's (1994) review of theoretical developments in medical anthropology offers a critique of notions of culture reduced to observable but unmotivated behavior or the cognitive contents imagined to reside "in one's head." He describes the recent theoretical movement away from "a medical social science focused on belief and behavior" and toward "meanings and experience" (Good 1994:5; see also Good 1977; Good and DelVecchio Good 1981). Good's (1994) analysis is illuminating for awareness of the ways in which the central analytic category of "belief" has been deployed historically and culturally in European and North American scientific and popular thinking. Going beyond culture characterized as "belief," this formulation includes the daily trafficking in paradoxes, puzzles, and fluidity characteristic of a "subjunctive mood" (Good 1994:153–8).

Sherry Ortner (1996:1–2) has argued that the cultural "making" of subaltern subjects – women, minorities, and, for my purpose here, the mentally ill – is accomplished in two ways. In the first, "cultural categories, historical subjects or forms of subjectivity are – passive voice – made (in that they are) constructed by, and subjected to, the cultural

and historical discourses within which they operate." The second arises (as introduced above) "from the actor's point of view" – where the "question is how actors 'enact,' 'resist,' or 'negotiate' the world as given, and in so doing, 'make' the world." This sort of "making" may amount to reproduction of "the same old cultural and social thing" or, "it may turn out to produce something new, although not necessarily what the actors intended. Indeed, intention plays a complex role in the process, for while intention is central to what the actor seeks to accomplish – and therefore must be understood very carefully – its relationship to the outcome is often quite oblique" (Ortner 1996:1–2).

To make known the theoretical erasures of the subject and agency characteristic of social and cultural theory of the past, Ortner convincingly argues two forms of analysis must constitute the anthropological project "in its fullest sense." She argues (1996:2) that, on the one hand, culture theory must include "practice theory" to reveal the ways in which "human action is constrained by the given social and cultural order (often condensed in the term 'structure')." On the other hand, in culture theory "there is also an insistence that human action makes 'structure' – reproduces or transforms it, or both" (Ortner 1996:2). This clarification of ethnographic and historical method, with the injunction against positions that "omit, exclude, or bid farewell to the intentional subject," is critical for the development of theories that do not make it a central theoretical point of organization to relegate the "abnormal" to a subordinate analytic status. Studies that begin to make this clarification with reference to depression and anxiety include the examination of state control of emotional discourse in Iran by Good and DelVecchio Good (1988) and my own examination of the Salvadoran political ethos as "the organization of feeling and sentiment pertaining to social domains of power and interest" (Jenkins 1991:140). With specific reference to schizophrenia, Warner (1985) has found a correlation between poor clinical outcome and economic downturns within nation-states; much more research along these lines is required.

Against the background of the tradition launched by Sullivan and Sapir, in the following sections I elaborate the assertion that psychotic-related symptoms and processes are not so distinctly and categorically different from the fundamental and ordinary processes of everyday life. I will take up this task with respect to self, emotion, social engagement, and cultural orientations. As a matter of subjectivity these are theoretically and experientially inseparable, indeed, even for Emil Kraeplin "loss of inner unity"[9] is central, and need not be construed as presuming that the self is an unchanging, bounded entity free of contradiction.

Nevertheless, for purposes of analytic clarity I will treat each of these domains successively.

The Self and Self-Processes

The position that the self is a basic phenomenon in all psychic life is argued by Karl Jaspers (1963:57) in terms of a "confrontation of a subject with an object," such that "*awareness of an object* may be contrasted with *self-awareness*." Irving Hallowell (1955) was among the earliest ethnographers to make his interest explicit by developing a notion of culture in relation to self-awareness. In the history of psychiatric inquiry into schizophrenia, the location of the self has shifted over time. Disorders of the self have been thought to be central to the psychoses in which, as suggested by Eugen Bleuler (1950), experience becomes constructed self-referentially in a world where fantasy and symbolization are continuously invoked.

Sullivan's theory of the "self-system" was conceptualized as a constellation of interpersonal mechanisms in service of emotional protection against a noxious emotional milieu (Sullivan 1953). Here the self is not a discrete and fixed entity but instead an intersubjective creation, a constellation of interpersonal processes developed during childhood and adolescence. However, though once regarded as the centerpiece of theoretical formulations, the self has receded to the periphery of contemporary psychological and psychiatric discourse concerning schizophrenia. The relative lack of attention to the continuity of self-processes in schizophrenia has been consistent with a focus on psychopathology and the way these processes are sustained. This shift, coterminous with the ascent of neuroscience and brain studies mentioned previously (see also Luhrmann 2001), has resulted in a most startling assertion regarding the self in schizophrenic process. The customary mental capacities and strategies we presume all humans to possess are often viewed as diminished or absent in people with schizophrenia.

The turning of American psychiatric attention away from psychological processes in schizophrenia is evident in their erasure from Diagnostic and Statistical Manual-IV (DSM-IV). While the previous edition of the diagnostic manual included "characteristic symptoms involving multiple psychological processes" such as alterations in "sense of self," these were entirely deleted from DSM-IV. New sections include "associated laboratory findings" and "associated physical examination findings and general medical conditions" (Jenkins 1998).

As a corrective to this theoretical retreat from the self, the core of my argument is that if we take the definition of the self as a set of processes and capacities for orientation and awareness, then we may learn something about the self by observing the manner in which experience becomes disoriented and by observing the struggle of those afflicted with schizophrenia to remain oriented in the world. Consider the ordinarily common experience of schizophrenia as "hearing voices" in relation to fundamental self-process. In culturally sanctioned settings such as religious communication with spirits or ancestors,[10] or the ingestion of hallucinogenic drugs, the hearing of voices is generally transient and not experientially at odds with the self (Karno and Jenkins 1997). In schizophrenia, voices tend to be habitual (though not continuous at all times), and the self-process of orientation in the world is undermined by both the lack of an appropriate setting and the absence of volition, such that the self is experienced as distinctly and profoundly different. In this respect, a sense of being at odds with intrusive auditory experience is the basis for an embattled self with whom the voices wreak havoc with respect to power, desire, and control.

There has been a swell of anthropological writings specifically concerned with the self during the last three decades (Gaines 1982; Shweder and Bourne 1984; Ewing 1990; Csordas 1994b; Battaglia 1995). On the basis of ethnographic evidence, the idea of the self as standardized in terms of psychologized, internal experience has been shown as an instance of how a European-derived ethnopsychological[11] category may become reified in social scientific thinking (Shweder and LeVine 1984; Lutz 1988). Such understandings of the self have been supplanted in cultural and psychological anthropology by a notion that among many peoples the self is constituted more fluidly and with far from determinate boundaries.

If we take culture to be an orienting axis for interaction with others, a useful formulation is Thomas Csordas's recent definition of the self as "an indeterminate capacity for orientation, characterized by effort and reflexivity" (1994b:5). Csordas's (1994b) argument for a new paradigm of embodiment in anthropology is critical in requiring studies of the self to be conceptualized not "from the neck up" but rather from the starting point of bodily experience. Such a strategy aims to avoid the methodological error of conceptualizing the self as a cultural category that refers primarily to "mental" phenomena.

Consider the following interchange between interviewer Ira Glass and Patricia Deegan (1997).[12] Deegan is a psychologist and a self-avowed "voice hearer," and is both reflective and articulate with respect to the phenomenology of her illness. At the outset, Glass mistakes the common

experience of hearing songs in one's head for the hearing of voices in schizophrenia. Deegan tries to correct this error, describing voices as a "primordially, profoundly auditory experience, to the point where you can actually startle if a voice starts up suddenly." She asserts that this auditory phenomenon is not "on a continuum" of what everyone hears in auditory imagination – one does not "really" hear a song in one's head. Yet despite this experiential discontinuity with ordinary experience, Deegan does not count them as discontinuous with self:

IG: How do you conceive of the voices that you hear? As *separate* from your self, or do you conceive of them as *part of* your self that you can recognize?

PD: I think that for me it's a goal to eventually say these voices are a part of me, and that's actually one of the self-help coping strategies that I do use sometimes. . . . So, for instance, if I have a particularly derogatory or awful voice, that I might say, as a coping strategy, 'today *I am feeling like* I am no good, today *I am feeling like* I'm a worthless person, these are *my* thoughts, these are *my* feelings.

IG: Is that because when the voice is saying that, literally you are *not* having the feeling 'oh, I'm feeling bad today.'

PD: That's right.

In this excerpt, the reflexivity that characterizes our capacity for orientation cannot be taken for granted by the self, and is crystallized, or rendered experientially opaque, in the voices. Yet Deegan's trained capacity for self-awareness allows her to reappropriate her own reflexivity by insisting that the voices are part of herself. Deegan's account also shows that orientation is not an effortless outcome, for resistance is encountered at the interface of subject and world. As with reflexivity, this effort, which is the taking up of a stance in the world, cannot be taken for granted by the patient. It appears as a moral uncertainty that is amplified in the voices' accusation that the self is "bad." Assertion of moral goodness, literally the right to be in the world, is the surplus effort required for Deegan to become oriented in spite of her affliction.

Deegan's experience leads me to another dimension of subjective experience at issue for the self, a dimension in which intentionality, agency, and meaning coincide in schizophrenic process. Here I use the term "intentionality" in its general existential sense of an implicit tending toward and taking up of aspects of our world. It is the condition of possibility for the kinds of self-processes of orientation that speak, linking us to everything in our world, constituting the texture of relationship

to it. In this sense the "voices" can be understood as intentional without being intended. Deegan describes a phenomenon in which agency catches up with intentionality in a remarkable form of intervention.

IG: You say that some people have found that putting an earplug in an ear can greatly reduce or eliminate distressing voices.

PD: Yes, this is an interesting finding. And empirically what they have found is that, putting the wax in both ears does not work. You have to try, through trial and error work with your right ear, then your left ear. For some people, for instance, putting it in the right ear, leaving it there for fifteen minutes will interrupt the voices and in some cases make them go away. For other people, you leave it in the right ear for fifteen minutes, and it's only when you take the plug out that the voices are interrupted and/or stopped . . .

IG: Is it just as simple as 'well, let's just change the situation' and just any change, like any sort of physical change might help?

PD: I think frankly, after my studies and also through a lot of personal trial and error and learning experiences myself, that there really is enormous truth that (it's) anything that promotes a sense of personal efficacy and power. That seems to be the key that, these voices which present themselves as these all-knowing, all-powerful, 'we know everything,' 'we see everything you do,' and on and on and on. To find that I can interrupt that powerful a force, really creates a space for me to have some power. And of course, this flies in the face of much of what modern psychiatry is saying. That people who are experiencing major mental illness are having 'broken brains' and can't possibly take a stand towards what's ailing them except to take medications. I feel we're doing an enormous disservice in the United States in particular by saying that medications are the only answer.

What is critical about the use of earplugs as a bodily practice is that plugging two ears doesn't work, an embodied recognition that the voices are not from outside the self and they can be blocked from entering through the ears. The same conclusion can be drawn, perhaps even more vividly, from the observation that the voices are in some cases affected only by *removing* the plugs. Finally, the indeterminacy of the self-processes is implicit in that the voices are often interrupted or suspended, but not necessarily eliminated in a definitive way. Deegan and her patients carry the earplugs for use when necessary rather than leaving them in as a permanent measure.

I would also take Deegan's own understanding in terms of agency/power/control one step further to include meaning. It will hardly be lost

on readers that the use of earplugs can be interpreted as a kind of placebo intervention. However, this is only helpful insofar as we follow Daniel Moerman's (2002) recent reconceptualization of the placebo effect as a "meaning response." There is an error in a truncated conception of placebo as in all respects inert and nonspecific in effect, for the placebo often creates meaning that carries a highly specific efficacy. In this respect the technique of the earplugs is not just an exertion of power against power, but also a meaningful metaphor of reappropriating one's own intentionality. It thus embodies self-process aimed at resecuring the capacity for orientation in the world and hence the very possibility of having a self.

The possibility has been raised that a discursive model of human experience may be useful in helping someone who experiences verbal hallucinations. In a case study of a woman's personal narrative, Davies, Thomas, and Leudar (1999) explicated verbal hallucinations as a variety of inner speech in which a supportive voice created a dialogic space of response to distressing and dangerous voices. In this instance, the inner dialogue was a singularized self process that created personal efficacy and power.

Neuroimaging studies have shown that when patients actually hear voices their speech perception and production network is activated in a way that suggests that hallucinations result from the "misattribution" of inner speech as coming from an external source (Hoffman 1999; Stein and Richardson 1999). While psychological attribution theory may be a narrow cognitive model for human experience, Anthony Morrison (1999:298) has suggested that "auditory hallucinations are normal phenomena and that it is the misinterpretation of such phenomena that cause the distress and disability" commonly experienced by patients. In a comparison of three groups of patients with schizophrenia, patients with dissociative disorder, and nonpatient voice hearers, Saeed Wahass and Gerry Kent (1997) found that the nonpatient group, unlike the patient groups, perceived their voices as predominantly positive: They were not alarmed or upset by their voices and felt in control of the experience. For most patients, the onset of auditory hallucinations was preceded by either a traumatic event or an event that activated the memory of earlier trauma. This study presents evidence that the form of the hallucinations experienced by both patient and nonpatient subjects is similar, irrespective of diagnosis. Differences between groups were predominantly related to the content, emotional quality, and locus of control of the voices.

These newer interpretations of voices are critical to my argument here in supporting the role of agency and intentionality of the auditory hallucinating self-based on neuroscientific, discursive, and cognitive studies of

these particular forms of subjectivity (Carter, MacKinnon, and Copolov 1996; Leudar, McNally, and Glinski 1997; Rojcewicz and Rojcewicz 1997; Behrendt 1998; Close and Garety 1998). Analysis of the cultural specificity of these processes has barely begun,[13] although Wahass and Kent (1997) have identified differences in coping strategies among Saudi and British patients. The strategies differ since the former invokes religion to account for voices and the latter invents techniques for distracting themselves or physiologically self-stimulating.

Against the background of these considerations, I encourage a research agenda aimed at exploring how people with schizophrenia think, have awareness, feel desire, self-protect, make social attachments, negotiate a gendered identity, deploy psychological defenses, enact personally encrusted transference dynamics, and act with agency and intentionality in the pursuit of goals that are considered reflectively. Such an agenda allows for a rereading of classic texts in a new light as in Silvano Arieti's (1955) rereading of Freud's 1896 study of projection and repression in relation to hallucinatory experience in schizophrenia. As is also the case among persons without schizophrenia, repression of self-reproach, for example, can be projected on to others who thus become the persecutors (Arieti 1955:23). For Arieti, Freud's greatest contribution in this area was his recognition of the importance of symbolization in the formation of schizophrenic symptoms. Other psychoanalytic concepts, including the unconscious, repression, and transference, are equally valuable for understanding the subjective experience of schizophrenia. "For instance, the unconscious decreases in extension in schizophrenia, as a consequence of a partial return to consciousness of what is generally repressed in psychoneuroses and normal conditions" (Arieti 1955:26).

Finally, it is worth pointing to the manner in which themes of self-hood can be identified by offering examples from my own explorations of the subjectivities of Latino and Euro-American patients with long-term schizophrenia or depression (Jenkins 1997:24). First, there was a subjective sense of engagement in what can be termed the *rhythm of life*. Often there appeared to be a moral struggle represented in narrative themes of "good" or "bad" self-perceptions as in relation to maintaining an embodied sense of rhythm and involvement in the flow of everyday activities. Second was the self-experience of temporality. The phenomenology of feeling ill may take the temporal form of flashes, moments, or waves that come and go and are not objectified as enduring identities. For example, Julia, a person who steadfastly discarded the notion that she was "ill," described her problems as "just part of my personality." She conveyed that she was "obsessed with the passage of time." She wondered what she might do the rest of the day and said that she is always thinking of

time and how to fill it. Third was the strategic attempt to represent to self and others that one was not marked by the stigma of mental disorder: Euro-American patients often invoked the category of physical illness to achieve this end, while Latinos described their illness in terms of *nervios* to achieve the same end. The fourth theme of self-hood was the implicit or explicit hope for recovery. In Byron Good's (1994:153) formulation, illness stories portray a "subjunctive world, one in which healing was an open possibility even if miracles were necessary." The subjunctive state of distress, misfortune, and illness is particularly impressive in the illness stories of our Latino respondents, for whom cure, recovery, and miracles were distinct possibilities (Jenkins 1997). The play of such themes across everyday life need not entail coherence of self or identity, and may play their own role in the perpetuation as well as the amelioration of suffering.

The Feel of Schizophrenia

Problems with emotion have long been considered an important aspect of the schizophrenic disorders (Sullivan 1927; Flack and Laird 1998). Yet there are a number of apparently contradictory formulations of what these problems might be,[14] and the repertoire of emotions and distortions of emotion are not well described in the literature. Perhaps the most critical issue with respect to emotion in schizophrenia is a pervasive clinical expectation that illness entails a flattening or blunting of affect. This expectation of flattened affect can be traced to the observations of Kraeplin (1919) in relation to the syndrome he termed *dementia praecox*. Bleuler (1950) sought to modify this characterization by emphasizing that affectivity is not absent in schizophrenia, but a complex and defining feature of the illness itself. Bleuler identified ambivalence – by which he meant the noteworthy simultaneous occurrence of opposing feelings for the same subject-object – as central to schizophrenia. Sullivan's formulation of the problem highlighted the exquisite sensitivity of emotional life.

> We find that the schizophrenic is an extremely shy individual, extremely sensitive, possessed of a singular ability to get his feelings hurt, who has rather naturally erected an enormous defensive machinery between himself and intimate contact with other people. (Sullivan 1962:223)

Over time, however, Kraeplin's formulation (1919:32–5) of an "emotional dullness," "ataxia of the feelings," and "blunting of emotions" dominated psychiatric characterization of a distinct absence of emotion in schizophrenia.

Contemporary psychiatric researchers conceptualize the claim of difference in schizophrenia patients' emotionality relative to their normal

counterparts, as well as to patients with other disorders, as a deficit (Andreasen 1994) that is classified among "negative symptoms" according to the DSM-IV criteria (American Psychiatric Association 1994). This scientific conceptualization – along with the popular notion that having emotion qualifies as the *sine qua non* of being human – provides challenges for anyone diagnosed with schizophrenia. That is, the perception that such persons do not have emotions may compromise their claim to human status. In this respect, a convergence of popular and professional construction of persons with schizophrenia as something "other" than human transpires. This lack of emotionality, then, serves to construct people with schizophrenia as less than fully human. The counterpoint to the argument that the lack of emotion is irrational, and hence inhuman, is that schizophrenic emotion is intensely disorganized. This leads ironically to the same cultural conclusion, that "the schizophrenic" is irrational, and hence, less than human.

To compound the irony, when emotionality *is* recognized within schizophrenia, it is often to amplify the imputation of irrationality. This is the case, for example, when instances of "schizophrenic rage" are sensationalized in the popular media. To grant a diversified emotional life to patients from the outset would be to recognize that rage is hardly unique to schizophrenia, and that such outbursts must be considered along with instances described as "road rage" or "hockey rage."[15] It is as unacceptable to regard a specific emotion as a symptom of schizophrenia as it is to diagnose the individual erupting in "road rage" with schizophrenia.

A stance that emphasizes what schizophrenia can teach us about fundamental human processes might foster research that encompasses *disorganization* while at the same time, moving beyond it to apprehend the *complexity* of emotion and thought in this illness. Forrest (1965:9) has analyzed language use of persons with schizophrenia to find that "(i)t would seem that in a real sense the schizophrenic is forced into an act of poiesis, and that in using language he is *making* something, not merely describing something, or performing, or communicating, or giving vent to something." Although much of schizophrenic speech is poetic, clearly there is no such thing as "schizophrenic language:"

Many of the peculiarities of the schizophrenic's speech may indicate, not that he is incapable of 'using words like somebody else,' but that his inventions and aberrations are purposive. That the poets in their mastery may have used words similarly is evidence of this, when it is shown that the poets and the schizophrenics have in common the search for an external order in language to lend authority to similar wishes. The wishes of schizophrenics have been assumed to be like those of other men, including poets. (Forrest 1965:18)

The final sentence of this quote perhaps begs the question of whether poets are like other persons, and whether poetic language is like everyday language. The issue is not whether to place the poet on the side of the normal or the abnormal person, or to set up poetry as a bridge or transitional form between normal and abnormal speech. It is rather to remind us that the figurative use of metonymy, synecdoche, and other devices in their language use are part of normal speech. Take, for example, Renee's narrative from *Autobiography of a Schizophrenic Girl* (Sechehaye 1951):

I saw things mocking me. I cannot say that I really saw images; they did not represent anything. Rather I felt them. It seemed that my mouth was full of birds, which I crunched between my teeth, their feathers, their blood and broken bones were choking me.

Here we have an embodied first-person account of an exceptionally threatening situation that experientially melds image and emotion. While it could be argued that not all persons with schizophrenia are similarly verbal, it remains that the methodological challenge to observing and interpreting diverse linguistic devices for affective communication should not dissuade us from attempting to apprehend subjective experience (see Saris 1995).

That humanity is precisely what is at stake is well known among those who live with schizophrenia as a matter of first-person subjectivity and intersubjectivity in family contexts or clinical and research encounters. The ironic fact that the suffering of persons with schizophrenia is substantially constituted by others' (healthcare providers, employers, kin, neighbors, strangers in the community) cultural ambivalence and reluctance to grant them full "human" status was made explicit in a recent field encounter by one of the members of our research team. After a series of informal interviews and numerous weekly trips to a fast-food restaurant, one of the ethnographers for our research team witnessed a moment of spontaneous relief experienced by a patient named Mark who announced quite abruptly: "Sarah, you see me as *human*."[16]

The foregoing considerations reveal a paradox in the research and clinical representation of the subjective experience of emotion among persons with schizophrenia. They are represented as "vacant," without emotional register, dull, flat – yet they are exquisitely sensitive to socioemotional communications. This paradox can in part be resolved with reference to a series of studies by Ann Kring and colleagues (Chapter 13 this volume; Kring and Neale 1996), who carefully insist that emotion phenomena must be specified with respect to behavioral and bodily manifestation, on the one hand, and subjective self-experience, on the other. Kring's work shows that although the experiential realities of schizophrenia patients

are suffused by as much or more emotion than their "normal" counterparts, an apparent emotional "discontinuity" may indeed exist between behavioral expression and subjective experience, particularly insofar as customary facial expression cues are (not) necessarily displayed. Thus, while an emotion may not be "readable" to an observer, it can nonetheless be experienced and reported upon by the person, and may also be accompanied by "readable" physiological indicators such as muscle activity (Tarrier, Vaughn, Lader, and Leff 1979). In this light, the characterization of persons with schizophrenia as having "flat affect" appears related to two analytic errors:

1. Conflation of experience with expression of emotion – certainly the failure or inability to draw upon the cultural repertoire of what Hildred Geertz (1959) referred to as the "vocabulary of emotion" can result in doubt or accusation regarding one's social competence and moral status as "human."

2. Clash of perspectives between observer and subject – this is in fact a failure of intersubjectivity. Here, the arrogation by the observer (whether clinician, researcher, family member, or partner in casual social interaction) to represent the subjectivity of the afflicted casts doubt on the legitimacy and veracity of patients' claims regarding their own emotional experience.

The World Health Organization's (WHO 1979) International Pilot Study of Schizophrenia (IPSS) was a longitudinal investigation of schizophrenic symptomatology and course of illness for 1,202 patients in nine countries (United Kingdom, former Union of Soviet Socialist Republics, United States, Czechoslovakia, Denmark, China, Colombia, Nigeria, and India). Two-year, follow-up data provide a striking range in the presence of flat affect: from 8 (Ibadan, Nigeria) to 50 percent (Moscow, Russia) of patients were so rated.[17] Whatever the methodological difficulties, these IPSS follow-up data for flat affect were reported as the second most common symptom present for the sample overall.[18]

Given the problematic status of flat affect, it is all the more important to observe that the repertoire of strong emotions characteristic of subjectivity under conditions of schizophrenia is not well described in the literature. In the domain of painful and upsetting emotions, perhaps anxiety, fear, and terror are the most common. These affects, attached to specific or generalized sources, may be extraordinary in intensity and duration. Margaret Sherman, a thirty-two-year-old Euro-American woman, explained to me that she nearly always felt anxious, particularly at night before going to sleep. When I asked her what happened when going to sleep she said, "I worry. What if I forget something, like my brush, or my purse, or the birds, or the *sky*?" This sweeping array of world-constituting

objects – at once personal and mundane, small and grand – cannot be taken for granted by her as ordinary and stable objects in her world. The objects and the attendant worry she attaches to them are arguably ordinary, yet her anxiety is extraordinary in frequency and scope. This means that the routinization of her daily experience cannot be taken for granted.

Beyond anxiety, the subjective feel of schizophrenia is frequently shaped by fears and abject terror (Corin this volume). The source of fear or terror may be threatening or horrifying voices, visions, and ideas as some of the foregoing examples have indicated. These frightening emotional forays lead to another dimension of the illness experience that is not sufficiently appreciated, that is, that psychotic experience – occurring transiently and unpredictably – is traumatizing (Shaw, McFarlane, Bookless 1997). Sergio Sanchez, a young Mexican man, explained that he felt in a state of fear. At the time, his new neuroleptic medication (Haldol) had not made as much of an improvement as he and his doctor and family had hoped. An exceptionally bright student, his plans to continue his studies at a local institute of technology were shattered since his cruel and oppressive voices ruled the roost when it came to his daily schedule. He would arise in the morning to make plans for studies and attendance of classes only to be thwarted by his voices that informed him otherwise:

Now, let's lie down on the bed and think about all the bad things you've done. You're worse than a child molester. You'll be lucky if you burn in hell. Imagine how it will feel to have your flesh burn. You think you're something? You're nothing and we'll show you.

Sergio knew not to ignore the voices since, after much thought, he had concluded that indeed this was the voice of God. He did not understand why God tortured him with these thoughts, which left him stunned and shaking. The trauma of such enforced rituals can, of course, become unbearable. This is likely why some 10 percent of persons with schizophrenia commit suicide: It is simply beyond endurance. Yet the fact that most do not, in spite of horrific and unspeakable suffering, points to the deep wellspring of human endurance and resilience when confronted with arguably the most painful and horrifying of human experience imaginable.

The occurrence and form in schizophrenia of positive emotions such as hope, contentment, joy, and humor, has received little attention. The relative eclipse of more positive emotions may be due to the intensity and prevalence of hard affects commonly noted. While less dramatic than the horror and the fear engendered by psychosis, positive emotions may well be part of everyday emotional experience. This was remarkable, for example, among a group of long-term and severely ill Latino and

Euro-American persons diagnosed with schizophrenia and depression for whom the subjunctive mood (Good 1994) of hope nonetheless colored the course of their lives and illness experience (Jenkins 1997). While some patients claimed they were unable to remember or imagine their lives in so-called "normal" terms (that is, when they were not ill), they had lost neither the desire nor the hope that somehow things might change for the better. Although this sense of hope and faith was articulated (implicitly or explicitly) among both ethnic groups, it was more apparent among the Latino (predominantly Puerto Rican) group. Latinos invoked their religious hopes as the basis for assuming that anything was possible, be it a medical cure or a miraculous divine intervention.

With the advent of the newer antipsychotic drugs (such as Clozapine, Risperidone, and Olanzapine) over the last decade, there have been some remarkable improvements described as "awakenings" (Sacks 1990) as occurred in people with postencephalitic Parkinsonism treated with L-DOPA. Significant recovery from psychosis often involves self-processes of newfound joy and satisfaction, on the one hand, alternating with recrimination and humiliation, on the other (Weiden, Aquila, and Standard 1996). According to Duckworth, Nair, Patel, and Goldfinger (1997:227):

When a patient experiences a significant reduction in psychotic symptoms . . . (t)he challenges inherent in such improvement often involve a fundamental re-assessment of one's identity, relationships, and purpose in being. When the hallucinations, tangential thinking, or delusions are quieted, patients are 'free' to reassess their status in life. During this period, many of them have reported periods of emptiness, disillusionment, sadness, loss and anger. The psychological reaction to dramatic pharmacological response is largely uncharted territory.

Duckworth and colleagues (228) found that "patients experienced a process of psychological redefinition and confronted developmental tasks that were dormant prior to their improvement . . . including three issues that challenge this population: sense of self, sense of connectedness, and sense of purpose." Difficult affects, such as anger and loneliness, joy and contentment, are also likely to surface. Social relations, once distant or broken, may be renewed with relative success or failure. These claims of dramatic changes in the subjective reactions and social relations of patients present major challenges in the clinical management and scientific understanding of schizophrenia (Weiden and Havens 1994; Weiden, Scheifler, Diamond, and Ross 1999). In our current research project on schizophrenia (N = 90) with persons treated with atypical antipsychotic medications, we find that the process of recovery – while substantial and discernable both objectively and subjectively – is better characterized as

incremental rather than *dramatic* through reference to the metaphor of "awakenings" (Jenkins and Miller 2002).

Spontaneous laughter and joke telling are also part of the more recent emotional landscape of subjective experience among persons who have experienced improvement in their condition. In one of the community clinic settings where our research team is conducting research, the waiting room has become a site for ritual performances of joke telling: "Hey: when you talk to God it's called prayer, but when he talks *back* it's schizophrenia," among a myriad of others. Although analysis of these ethnographic (and other interview) data is ongoing, it is clear to us that poking fun at "the illness" and "medications" is highly relished.[19]

Social Engagement, Cultural Orientation

Sullivan conceived of mental disorder as an interactive process. As a starting point for cultural investigation, it requires that mental disorder be examined within the arena of everyday social life rather than in the brain scan or clinic (Scheper-Hughes 2001). The early theoretical formulations by Sullivan provide a bridge between the subjective experience of the afflicted self and the world of everyday social interaction. A more recent consideration of this issue has been set forth in Jessica Benjamin's (1995) *Like Subjects, Love Objects: Essays on Recognition and Sexual Difference*. Benjamin notes that, in the strict sense, no subject ever constitutes herself in the absence of other subjects and objects. In this sense, I would suggest, when we speak of subjectivity we actually mean to invoke the notion of intersubjectivity. Indeed, Benjamin supplants classic formulations of "object relations" with the notion of intersubjectivity in asserting "where objects were, subjects must be." The idea of intersubjectivity has been formulated in deliberate contrast to the logic of subject and object through entry into the interactive zone of lived experience in which the self is processually, dynamically, and multiply constituted.

The theoretical reformulation of differences between subject and object, self and other, entails finding a way to account for the difficulty each subject has in recognizing the other as an equivalent center of experience. In the case of schizophrenia, potential failures of recognition can be two-edged: There may be a staunch cultural refusal of others to grant the ontological status of subjects to "schizophrenics"; and, among persons with schizophrenia there can likewise be a strained ability to grant the legitimacy of subject status to others. The tension of sustaining the contradiction of intersubjective structure, which includes mutuality, simultaneity, and paradox, can lead to a common fact of mental life: the breakdown in the relation between self and others in favor of relating as

subject and object. Even so, a developmental formulation of this problem underscores the fundamental need humans have for *recognition* and a *capacity* to recognize others in return (Benjamin 1995).

If the understandings of subjectivity and social engagement as formulated by Sullivan and Benjamin are valid where schizophrenia is concerned, the clinical and popular assumption that psychotic persons do not respond emotionally to their social surroundings cannot be tenable. This assumption may stem from the idea that psychotic experience is so self-consuming that persons experiencing psychotic symptoms (hallucinations, delusions) are not capable of taking note of or responding to features of their setting (a variation on the "nobody's home" model of flat affect as characteristic of subjective experience described previously). That this conceptualization of persons with schizophrenia is mistaken is clear from empirical studies illustrating that they are not only fully aware of their socioemotional surroundings but are particularly responsive to them. This is not only a matter of daily life experience; even more significantly, these processes of social engagement mediate the clinical course of illness defined in terms of improvement and recovery. Clearly, the understanding of these processes is of primary importance.

There are several areas of empirical research that are critical in demonstrating the significance of social relations and engagement for persons with schizophrenia: (1) family "expressed emotion" in cross-cultural perspective; (2) the relationship of "expressed emotion" to cultural interpretations of the "problem" conceived by researchers/clinicians as "schizophrenia"; (3) the type of emotional style adopted by patients toward their social world; (4) the relationship between gender and recovery; and (5) the importance of social ecology (as type of residential setting) as a mediator for treatment response.

First, there has been extensive research to demonstrate that the empirically derived construct of "expressed emotion" (that is, subjective data on criticism, hostility, and overinvolvement insofar as they constitute a particularly familial emotional ambiance) is significantly predictive of clinical relapse (Brown, Birley, and Wing 1972; Vaughn and Leff 1976; Vaughn, Snyder, Jones, Freeman, and Falloon 1984). Paul Bebbington and Liz Kuipers (1994) summarize a total of twenty-five methodologically comparable studies completed from around the world to produce an aggregate analysis confirming this relationship. Marvin Karno and colleagues (1987) extended this research beyond British and Anglo-American English speakers to determine that in a sample of seventy Spanish-speaking Mexican-descent families in California these emotion factors (1) also significantly predicted the course of schizophrenic illness; and (2) were found to be cross-culturally variable, with significantly lower

levels of criticism and hostility relative to their Anglo-American counterparts. Because much of this empirical research tradition had proceeded apace on the basis of statistical "prediction without meaning," we also took it upon ourselves to examine the theoretical nature and meaning of what was inside the empirical "black box" of expressed emotion, to conclude that this research construct taps a variety of culturally variable kin responses to the problem of schizophrenic illness in the family, in addition to features of social ecology and historically specific political processes (Jenkins and Karno 1992).

Second, our research on the meaning of indigenous conceptions of schizophrenia produced the finding that such conceptions substantially determine the emotional response ("expressed emotion" as above) to the problem (Jenkins 1988a). That socially transacted (kin and community) cultural orientations "make" reality by specifying the conceptual-emotional parameters of "schizophrenia" (*nervios* or laziness, for example) such that they mediate the emotional response (warmth/sympathy or anger/hostility, for example) and thereby shape the actual course and outcome of the illness is powerful cultural evidence that there is no such object as a "natural" course of schizophrenia (Jenkins 1988b, 1991). Rather, the course of illness is inherently social and cultural, and a matter of intersubjective engagement. Thus, the import of culturally specific conceptions of schizophrenic illness extends beyond the question that came to dominate psychiatric anthropology during the 1960s and 1970s. At that time anthropologists wanted to know, in effect, whether "what was crazy for us was also crazy for them" (Edgerton 1966). They investigated the issue by analyzing indigenous conceptualizations of what would, by "Western" standards, be diagnosed as psychiatric disorder (Kennedy 1974; Waxler 1974; Janzen 1978; White 1982; Scheper-Hughes 2001). Taking into account the kind of concerns I have raised here promises to help make sense of the array of disturbances in body, mood, thought, and behavior that so perplexes families of afflicted individuals. Family members' attempt to arrive at any understanding of the problem, however tentative or imperfect it might be, is invariably guided by sociocultural models of illness (Jenkins 1988a). These models, along with their associated emotional response, mediate the course and outcome of mental disorder (Jenkins 1988a; Jenkins and Karno 1992). Specifying the cultural variation in the course of schizophrenia (WHO 1979; Kleinman 1988; Hopper this volume) thus goes to the heart of a critical feature of illness experience: recovery.

A third area of empirical research in which social engagement has been observed as key to the course of illness concerns the type of emotional style patients adopt toward their social world, again in many cases

prominently including kin (in this case, siblings). In her study of male patients in Montreal, Ellen Corin (1990) found that men with schizophrenia developed two styles of social distancing. The first type remains voluntarily and purposively "detached" from others as a protective strategy; the second pattern is experienced as being involuntarily "excluded" by others.[20] More men who employed the "excluded" style were rehospitalized than those who remained voluntarily more detached. Thus George Devereaux's (1939) characterization of schizophrenia as an adaptation to loneliness was found to vary according to personal style of organization. Based on available scientific literature, we might also expect this to vary in relation to gender.

Fourth, in the last decade there has been increasing recognition of the role of sex and gender in schizophrenia.[21] Women have been found to have later onset of illness, more affective-type symptoms, better response to treatment, and superior course and outcome (Goldstein and Tsuang 1990). In a study comparing schizophrenia and depression among eighty Latino and Euro-American households, we found that the only statistical main effect in the area of social and household functioning is accounted for by sex, with women doing far better in this domain than their male counterparts (Jenkins and Schumacher 1999). We also observed that in these family settings, women with schizophrenia – like their normal counterparts – carry out the lion's share of household work and management relative to men. Kaplan's (1991) analysis of sex and gender differences in psychopathology invokes the notion of variations in psychological strategies that require a performance of socially enacted gender stereotypes.

Finally, the significance of social engagement for persons with schizophrenia has been empirically specified in relation to subjective response to personal therapy and residential setting (Hogarty, Kornblith, Greenwald, and DiBarry 1995). In this American study, patients living with family and receiving personal therapy treatments have a significantly better course and outcome compared with patients living independently. For the latter group, a reverse effect was noted: Patients who received personal therapy but lived alone or in group-home settings experienced significantly more psychotic decompensation. The particular technique developed for "personal therapy" here entails patients learning to identify their subjective states – particular their affective states – and the development of appropriate social perception – that is, learning to gauge one's own and another's "emotional temperature" and selecting a likely successful response before initiating an interpersonal encounter. While patients living with family were able to benefit from this therapeutic method, the authors suggest that patients living apart from family may

have experienced personal therapy as a cognitive overload. In addition, these patients were forced to cope with subsistence issues on an everyday basis. They suffered with greater difficulty securing food and clothing, and suitable, stable, and conflict-free housing. The critical importance of household conditions and social relations had already been empirically demonstrated as etiologically predictive for depression (Brown and Harris 1978). This research shows not only that these factors are likewise significant for persons with schizophrenia but also that such conditions mediate their ability to engage positively in particularly types of therapeutic interventions where monitoring of their own subjectivity is concerned.

Conclusion

In *A Beautiful Mind*, Sylvia Nasar (1998) examines the life of mathematical genius John Forbes Nash, afflicted with intermittent bouts of florid schizophrenia since the age of thirty. While eventually awarded the Nobel Prize for his contribution to economic game theory, committee deliberations about Nash were constituted in large part by a fierce, if often subterranean, antipathy toward a "schizophrenic" as recipient since, as framed by one committee member, "(h)e's sick . . . you can't have a person like that." After all, "[W]hat would happen at the ceremony: Would he come? Could he handle it? It's a big show" (366). In the end, other committee members prevailed with the view that "on the whole, Nash (was) no more eccentric, irrational, or paranoid than many other academics" (362). Be that as it may, Nash's personal experience of psychosis, no less his intuitive flights of mathematical genius, renders him *just like us but very much more so*.

In this chapter, I have examined the cultural grounding of subjective experience in schizophrenia as a paradigm case for understanding fundamental human processes, drawing on Sapir's interactional, meaning-centered theory of culture and on Sullivan's theory of schizophrenia as grounded firmly in the everyday world. With the added insights of a number of contemporary cultural theorists, I have examined particular processes of self, emotion, social engagement, and cultural orientation, all vital for the analysis of a complex phenomenon such as schizophrenia. The discussion is intended as evocative rather than definitive, and points toward further substantive research in each of the three domains.

First, in the domain of the self, the intersection of culture, subjectivity, and schizophrenia is perhaps most intense, most problematic, and most fundamentally human. In the experience of "voices," for example, the nuances of intentionality, agency, and meaning are intertwined in the

service of appropriating experiences that are profoundly discontinuous with normality into an ordinary self that is singularly continuous with normality. This analysis points toward power, resistance, and identity, each of them fruitful areas for further research.

Second, in the domain of emotion, schizophrenia has long been construed as a state of affective deficit. This could scarcely be further from the truth, for a groundswell of contemporary research is now beginning to show that it is emotional intensity and complexity that epitomizes this disorder, even for those whose emotional expression appears to others to be flattened out. Further studies are needed, with the breadth to encompass the extremes (abject terror) and the ordinary (hopes and disappointments). They will enrich our understanding, not only of schizophrenia, but also of human emotional processes per se.

Third, in the domain of social engagement, we have seen that persons with schizophrenia, like their counterparts, are exquisitely tuned to social relations and cultural orientations for their lives and illness experience. In particular, cultural conceptions of the illness are associated with particular emotions that affect significantly the clinical course of illness. This association, initially established for schizophrenia, has subsequently been found for other stress-related conditions, psychiatric and nonpsychiatric alike (Jenkins and Karno 1992). In addition, cultural orientations for gender and type of household affect the capacity to monitor personal subjective states.

In this chapter, then, I have maintained that the subjective experience of persons with schizophrenia invariably involves culture and agency. That their subjective experience is hardly voided by illness process runs contrary to many scientific and popular representations. In addition, I have argued that the study of schizophrenia illumines our understanding of culture and subjectivity more generally. Thinking with schizophrenia – perhaps ironically considered the "most" biogenetic and "least" cultural of psychiatric disorders – provides a compelling case for the necessity of conceptualizing fundamental processes and capacities as invariably mediated by culture and context. Moreover, because the experiences of people with schizophrenia can be quintessentially extraordinary just as they can be exquisitely ordinary, people who suffer from the disorder have a unique capacity to teach us about human processes that are fundamental to living in a world that is shared with others.

NOTES

1 In this chapter, we prefer usage of "person with schizophrenia" rather than "the schizophrenic."

2 This quote is taken from Sapir's reconstructed lectures (1994:224, 237) on "The Psychology of Culture" edited by Judith Irvine. Irvine's footnote for this quote has been incorporated in specific reference to psychosis.

3 Over the past few decades, there has been a proliferation of studies by anthropologists on culture and emotion (Geertz 1973; Rosaldo 1984; Shweder and LeVine 1984; Lutz 1988; Jenkins 1994a), notably Michelle Rosaldo's formulation of emotions as "not only self-concerning, partly physical responses" but also "aspects of moral or ideological attitudes" that are "of strategic importance to analysts concerned with the ordering of action and the ways that people shape and are shaped by their world" (Rosaldo in Levy 1983:128).

4 While there are various psychiatric views of schizophrenia – from the biological, psychosocial, cognitive-behavioral, to the psychodynamic (see Barrett 1996), this rich variety of theories and approaches is frequently eclipsed in relation to the lack of adequate funding when state and local mental health services provide services. Thus, providers often fall back on the biological perspective as the default option, feeling that it is the least, and perhaps the only, treatment option they can provide. In addition, over the last two decades we have witnessed the paradigmatic ascendancy of biological psychiatry across many academic schools and departments (Luhrmann 2001).

5 In this chapter, I rely on my ethnographic and clinical research experience over the past two decades, through a series of research projects funded by the U.S. National Institute of Mental Health on culture and schizophrenia: "The Course of Schizophrenia among Mexican-Descent Immigrants" (MH 30911), "Schizophrenia and Depression among Latinos and Euro-Americans," (MH 47920), and "Schizophrenia Experience and the Culture of Recovery through Atypical Antipsychotics" (MH-60232). Examples and illustrations for this chapter are taken from the data of these studies.

6 This assumption regarding an inevitable neurodevelopmental degeneration in the course of schizophrenia has been shown not to be true by virtue of international and cross-cultural evidence (Hopper this volume), neuroscientific (Lieberman 1994), or longitudinal (Harding 1987).

7 The notion of being "just like us only more so" has been invoked in a variety of contexts; see Jenkins (1988a) for the application of this point in relation to the fluidly applied concept of *nervios* as applied to schizophrenia illness among Mexican immigrants.

8 As more women theorists and researchers have become involved in the study of schizophrenia, and the National Institutes of Health have implemented the requirement to include women and minorities in scientific protocols, studies of schizophrenia have begun to include women.

9 The emphasis on "lack of inner unity" appears in Kraepelin's seventh edition of *Psychiatrie* (1903).

10 Hearing the voice of a deceased love one is not uncommon among many cultural groups (Karno and Jenkins 1997).

11 The term "ethnopsychology" refers to cultural assumptions about the mind, emotion, and the self (Shweder and LeVine 1984). Jenkins (1994b:100) has summarized ethnopsychological themes as "the relative egocentricity of

the self; indigenous categories of emotion; the predominance of particular emotions within societies; the interrelation of various emotions; identification of those situations in which emotions are said to occur; and ethnophysiological accounts of bodily experience of emotions. This constellation of sociocultural features will mediate how persons experience and express emotion."

12 Excerpts taken from an interview conducted by Ira Glass (1997) with Patricia Degan in a radio program on "The Edge of Sanity," for "This American Life," Public Radio International.

13 A general theory to account for the presence of positive symptoms such as auditory hallucinations has been that overstimulation (although understimulation may also be a trigger) is likely to provoke symptoms (Vaughn and Leff 1976).

14 The problem of emotion in schizophrenia is complicated in cross-cultural perspective, given recent anthropological formulations of emotion as culturally constituted (Geertz 1973; Rosaldo 1984; Lutz 1988).

15 "Road rage" is periodically reported on the highways of the United States, involving apparently unwarranted violent acts by one motorist toward another. "Hockey rage" refers to the episode widely reported in January 2002 of the manslaughter trial of the parent of a youth hockey player in Boston, Massachusetts, who killed his son's coach, and can be generalized to violent outbreaks on the part of parents of youth athletes in other sports.

16 This example is excerpted directly from field notes from NIMH-funded study MH-60232, "Schizophrenia Experience and the Culture of Recovery through Atypical Antipsychotics" (SEACORA).

17 Methodological questions regarding cultural validity linger since precisely how flat affect was assessed is not part of the published record. Part of the methodological challenge is to rate "flat affect" in terms of a quantitative continuum between flatness (pathological) and expressiveness (normal).

18 The most frequently reported symptoms, across sites, was "lack of insight," conceived as a failure to recognize the presence of illness. However, another cultural possibility exists: The IPSS data may indicate that what may have been apparent from an observer's point of view may not have been experientially true for the subject. The idea that the psychiatric interpretation of the presence of illness wherein the patient might claim otherwise seems evidence that there likely were instances of a clash of perspectives regarding the rating of symptoms.

19 This observation was noted by members of the research team for NIMH-funded study MH-60232.

20 In this study, patients attached a particular importance to their sense of being "excluded" from social participation with their siblings.

21 This has served to advance what Sandra Harding (1991) would term feminist empiricist "corrections" of the scientific record in "getting it (more) right" by virtue of analyzing data to include the dichotomously coded variable of "sex." However, studies in this area have yet to address the more challenging question that, again from Harding's (1991) point of view, would be termed feminist standpoint theory insofar as research is undertaken with a set of critical epistemological assumptions regarding the more complicated

question of gender. Thus far in the medical, psychiatric, and psychological literatures attention to gender as a cultural orientation has been largely ignored, but is the subject of the current NIMH-funded study MH-60232 (SEACORA).

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