“Making the Child Understand:”
Socialization of Emotion in Urban India

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Using a combination of quantitative and qualitative methods, this study examined mothers’ socialization of child emotion in suburban middle-class families in Gujarat, India. In particular, a community sample of 602 children, 6 to 8 years, was screened for emotional/behavioral problems using a parent-report measure standardized with this population. Based on the screening, four groups of children were formed: those with internalizing problems ($n=31$), externalizing problems ($n=32$), and somatic complaints ($n=25$), and an asymptomatic control group ($n=32$). Mothers of children across groups completed a previously pilot-tested, forced-choice, self-report questionnaire of their emotions and behaviors in response to their children’s anger, sadness, and physical pain, and an individual open-ended interview further exploring their socialization behaviors, immediate goals, and expectations from their children. Quantitative data revealed that mothers of children in internalizing, externalizing, and somatic complaints groups reported more negative emotions (anger, disappointment, embarrassment, restlessness) and punitive/minimizing behaviors than the control group, with the somatic-complaints group also reporting less sympathy and emotion-/problem-focused behaviors than the control group. Qualitative data provided a culturally grounded overarching framework to understand emotion socialization in this sample, and suggested variation across groups with respect to the type of mothers’ behaviors, along with expectations for appropriate behavior.

Keywords: culture, socialization, emotion, behavior problems, mixed-methods

Literature concerning the socialization of emotion in White middle-class families in the West has shown that individual differences in parents’ socialization of child emotion contribute to children’s psychological well-being (Eisenberg, Cumberland, & Spinrad, 1998). Unfortunately, there is little research that investigates how children are socialized with respect to emotions in other cultural groups, particularly in families whose children display emotional or behavior problems. Focusing on Hindu middle- and upper-middle class families in urban India, this mixed-methods study examined the ways in which mothers respond to emotions in children who are asymptomatic, as well as those identified as experiencing internalizing (i.e., depression), externalizing (i.e., aggression), or somatic problems. A mixed-methods approach is particularly well suited to the study of parental socialization because it facilitates an examination of the prevalence of specific socialization behaviors, as well as a deeper exploration of beliefs associated with those behaviors (Yoshikawa, Weisner, Kalil, & Way, 2008). We used quantitative methods to compare Indian mothers’ emotional and behavioral responses to their children’s expressions of anger, sadness, and physical pain across groups, and qualitative methods to further explore their socialization behaviors, goals, and expectations regarding appropriate child behavior.

The Cultural Foundation of Emotion Socialization

Cultures vary in terms of parents’ broader socialization goals (e.g., helping their child become an autonomous, self-reliant individual or a socially interdependent individual), and these goals shape their interactions and conversations with their children (Keller & Otto, 2009). Parents from suburban middle-class Hindu families in India, much like those in other Asian cultural groups (Chao, 2000), endorse relational social-
ization goals such as learning to obey elders, and care for others (Raval, Raval, & Deo, 2011). Relational socialization goals may be understood within a broader cultural model of interdependence (Markus & Kitayama, 1991) or relatedness (Kaufticka, 2005) that conceptualizes individuals as inherently connected to others. In these communities, emotions are experienced and expressed to serve the larger goal of maintaining social relationships and harmony. As such, emotions such as anger or sadness may be experienced but not readily expressed in the family to avoid conveying a discomfort with the social world that is harmful to one’s family relations, and in turn, to one’s sense of self (Markus & Kitayama, 1991). In this cultural context, then, an important goal of emotion socialization is teaching children to control “uncivilizing” emotions such as anger (Menon, 2000).

Studies of school-age Hindu children in rural Nepal (Cole, Bruschi, & Tamang, 2002) and urban India (Raval, Martini, & Raval, 2007) support the emphasis on control of perceived undesirable emotions. For instance, middle-class Hindu children in urban India reported controlling anger or sadness more than physical pain, the expression of which likely has relatively fewer negative consequences for one’s social relationships (Raval et al., 2007). How might adults teach children to control such feelings, and socialize them to be interdependent individuals? Traditionally, children in India grow up in households with various extended family members (parents, grandparents, uncles, and aunts) and, much like many other parts of the world, multiple female members participate in child rearing (Kurtz, 1992; Trawick, 1992). Socialization is considered a subtle process during which children learn to voluntarily renounce their desires and modify behavior in response to implicit messages of others, rather than explicit commands (Kurtz, 1992). Consistent with this account, in a Hindu upper caste, rural family in Tamil Nadu, South India, Trawick (1992) describes female caregivers as smacking and then affectionately holding a child in response to the child’s temper tantrums to teach the child about undesirability of the behavior without threatening his or her sense of agency. However, other research (Roopnarine, Talukder, Joshi, & Srivastav, 1990; Seymour, 1999) suggests that there is variation in socialization approaches among educated middle-class families. For example, in contrasting the caregiving approaches of traditional Old Town and modern New Capital in Orissa, Seymour (1999) reported that extended kin less frequently participated in childcare in New Capital families, and parents engaged in more explicit instruction and comforting than Old Town families. In suburban middle-class families in New Delhi, Roopnarine et al. (1990) observed mothers and fathers as smiling, vocalizing, and holding infants more than other relatives. Although a growing body of literature has explored socialization practices in India, the link between socialization approaches and child well-being has not been explicitly examined in Indian families.

**Emotion Socialization and Child Behavior Problems in Western Developmental Psychology**

Psychological literature based on White middle-class families in the West suggests that parents socialize their children’s emotions through their emotional and behavioral responses to children’s emotions, their discussion of emotion, and modeling of their own emotion (Eisenberg et al., 1998). With respect to parents’ emotional responses, parents’ negative emotions (e.g., anger, distress) have been linked with children’s difficulties in regulating felt emotion (Eisenberg et al., 1999), and positive emotions (e.g., warmth) have been associated with children’s empathy (Zhou et al., 2002). In terms of their behavioral responses, White middle-class parents respond to their children’s emotions with emotion- and problem-focused coping (i.e., help their children self-regulate by comforting them, or by helping them to solve the problem that caused the feeling, respectively), verbal or physical punishment, and minimizing the significance of the child’s feeling (Eisenberg et al., 1998). Findings indicate unique links between these parent behaviors and child outcomes in White middle-class samples. In particular, concurrent and longitudinal studies indicate that punitive and minimizing behaviors are related to externalizing (e.g., aggression) and internalizing problems (e.g., depression) in children and adolescents (Eisenberg et al., 1999; Zhou et al., 2002; Klimes-Dougan et al., 2007; Suveg, Zeman, Flannery-Schroeder, & Cassano, 2005). In contrast, emotion- and problem-focused responses are associated with improved social competence (Ramsey & Hubbard, 2002) and friendship quality (McElwain, Halberstadt, & Volling, 2007).

It is important to note that the impact of parents’ behaviors on child outcomes needs to be considered in light of the culturally prescribed socialization goals that are adopted by parents. Viewed in this way, parent behavior that is linked with compromised child well-being in one context may well be associated with optimal child functioning in another, depending on the cultural context (Leung, Lau, & Lam, 1998; Lindhal & Malik, 1999). For example, Raval and Martini (2009) found that urban middle-class Hindu mothers’ reports of punitive and minimizing behaviors (which are typically associated with undesirable child outcomes in the West) were positively related to their children’s self-reported control of anger, sadness, and pain—outcomes that may be viewed as positive in India. In contrast, mother reports of comforting and problem-solving behaviors (which are seen as positive in the West) were unrelated to Indian children’s self-reported control.

While an awareness of how culturally grounded socialization goals may influence the link between parent behaviors and child outcomes, it is also essential to ensure that a wide range of culturally relevant parental behaviors are studied. In Raval and Martini’s (2009) study with Indian mothers, for example, qualitative data indicated a culture-specific parent behavior that is not captured by Western quantitative measures. Specifically, in addition to problem-focused responses to child emotions (which are solution-oriented and common among White middle-class mothers), Indian mothers often reported giving the child an explanation of the situation, frequently phrased as “making the child understand.” Such an approach is in keeping with overarching relational socialization goals, which teach children to adjust their own goals and needs to fit their social environment and to accept the situation, thus facilitating their
development as socially interdependent individuals. Raval and Martini (2009) thus argued for the need to further explore problem-focused parent responses aimed at providing an explanation, in addition to a solution, in order to more fully capture the range of behaviors reported by Hindu mothers. Though Raval and Martini did not assess child behavior problems, they noted that such a step would be a valuable addition to the literature regarding Indian families.

The Present Study

The present study targeted Hindu middle- and upper-middle class families in Gujarat, India in which children were identified as demonstrating externalizing problems, internalizing problems, or as being asymptomatic (i.e., a control group). A fourth group of children presenting with somatic complaints was included because cross-cultural mental health literature suggests a tendency toward somatic idioms of distress in Asian cultures (Kirmayer, 2001). Thus, inclusion of both psychological and somatic problems may provide a wide range of concerns relevant to Gujarati children. These groups were studied with regard to mothers’ emotional and behavioral responses toward their children’s anger, sadness and physical pain. Qualitative research supports the cultural relevance of anger and sadness in India: In open-ended interviews with parents, anger and sadness were reported to be among the most frequently occurring emotions in the daily lives of Gujarati children (Pai, 1998). Physical pain was examined in this study because previous findings (Raval et al., 2007) have suggested differential acceptability and response patterns to children’s emotions (anger and sadness) versus physical pain in Gujarati families. Given the debate related to whether pain should be considered a true emotion (Izard, 1977), in the present study the term emotion is used to refer to anger and sadness, whereas the term feeling is used when the referent also includes pain. Using a quantitative measure, we first compared groups with respect to mothers’ emotional and behavioral responses to their children’s expressions of anger, sadness, and pain in an exploratory manner. Second, with open-ended interviews, we examined mothers’ emotions and behaviors related to socialization, along with their reasoning about both and their expectations regarding appropriate child behavior.

Method

Research Context

The research team consisted of Vaishali V. Raval and four undergraduate/graduate students in social sciences at Gujarat University in Ahmedabad, India. Ahmedabad is among the largest metropolitan cities in India with the population of about five million people (Census of India, 2001). The suburbs of the city house primarily the educated middle- to upper-middle class, and consist of relatively modern architecture with shopping complexes, multiplex movie theaters, and up-scale restaurants. In the suburbs, some family units continue to be joint, with extended family living together, whereas others have evolved to be nuclear, with only parents and children. Regardless of family structure, mothers tend to be homemakers with multiple responsibilities, including meal preparation, supervising the work of hired help, getting children ready and taking them to school, checking and helping with schoolwork, and taking children to tutoring and extracurricular activities. Other women (in joint families) and many fathers (in nuclear families) may also participate in these activities. Mothers who are employed outside the home are particularly likely to rely on other women in the family, fathers, or hired help to assist with housework and childcare. We focused on mothers’ reports of socialization, as they are considered more central than other caregivers in Indian middle-class families (Roopnarine et al., 1990), while acknowledging the participation of other family members whose perspectives are not included here. Traditionally, socialization pressures become more pronounced for Hindu Indian children after they turn 5 years of age (Seymour, 1999), though in educated middle-class families children may experience such pressures earlier. Nonetheless, we focused on mothers of 6- to 8-year-olds to capture the developmental stage in which socialization pressures may be most critical.

Members of the research team were closely familiar with the day-to-day life in middle- and upper-middle class suburban families in Ahmedabad, and spoke Gujarati fluently. Mothers were recruited from the second and third grades of five Gujarati-speaking elementary schools in suburban Ahmedabad, and all study measures were completed in Gujarati at the school. Mothers were informed that the goal of the research was to learn about their views regarding child rearing. However, mothers and school staff did sometimes seek advice from the researchers about child-behavior management, suggesting that members of the research team were likely perceived as “experts.” The overall research context likely influenced participants’ experiences, perhaps enhancing the potential for socially desirable responses.

Screening Procedures

A community sample of 6- to 8-year-old Gujarati children (N = 602; 326 boys and 276 girls) was screened for somatic, internalizing, and externalizing problems. Mothers of these children completed the Child Behavior Checklist-Gujarati Adaptation (CBCL-GA; Raval, Raval, Panchal, & Chakravorty, 2003), a parent rating scale translated from the widely used Child Behavior Checklist for Ages 6-18 (Achenbach, 2001), and previously standardized with a separate sample of Gujarati mothers. This measure was chosen after consultation with mental health professionals in Ahmedabad who reported the utility of a previous version of the CBCL (Achenbach, 1991) in identifying problem behaviors in Gujarati children. Consistent with their report of its clinical utility, the CBCL-GA showed good internal consistency (Cronbach’s alpha was .83, .88, and .93 for the Internalizing, Externalizing, and Total Problems Scores, respectively) and construct validity (as demonstrated by confirmatory factor analysis; Raval et al., 2003) supporting its relevance for use with this sample. Mothers also com-
completed a demographics questionnaire as a part of this screening, providing information about family structure, religion, income, education, and occupation.

**Participants**

Based on the CBCL-GA scores and the following inclusion criteria, four groups were formed for the main study \((N = 120\) total): Mothers of children who scored within the Clinical range (as defined by Achenbach & Rescorla, 2001) on the Somatic Complaints Syndrome Scale and within the normal range on the remaining Syndrome Scales formed the somatic-complaints group \((n = 25; 15\) boys, 10 girls). Mothers of children who scored within the clinical range on the Anxious/Depressed and/or the Withdrawn Syndrome Scales, and within the normal range on the remaining Syndrome Scales formed the internalizing group \((n = 31; 13\) boys, 18 girls). Mothers of children who scored within the clinical range on the Aggressive Behavior and/or Delinquent/Destructive Behavior Syndrome Scales, and within the normal range on the remaining Syndrome Scales formed the externalizing group \((n = 32; 22\) boys, 10 girls). Finally, mothers of children who scored within the normal range on all Syndrome Scales formed the control group \((n = 32; 17\) boys, 15 girls).

Informal teacher reports of children’s internalizing and externalizing behaviors were consistent with mother reports on the CBCL-GA, providing further evidence for the cultural relevance of these groups. For instance, teachers sought advice from the research team about managing the aggressive behaviors of children in the externalizing group, who were described by teachers as “very mischievous or naughty,” “having a hot-temper,” or “constantly quarreling.” The teacher of one girl who met inclusion criteria for the internalizing group independently reported, “She is overly sensitive and gets nervous easily. Every time I ask her to stand up and read to the class, she starts crying.” Children with somatic complaints were not brought to the attention of the researchers, likely because these complaints were considered physical in nature and more appropriately directed to medical professionals. Thus, the cultural relevance of somatic complaints (as identified by the CBCL-GA) is unclear, as we do not have information about how adult concerns about physical complaints are conceptualized in local terms.

**Demographic information.** No statistically significant differences were found across the four groups with respect to any of the demographic variables. A majority of families were Hindu upper-caste (82%). Fifty-nine percent of the mothers lived in joint family households (typically parents, grandparents, and children; mean number of persons in the household 6.63, standard deviation \([SD] = 2.17\), and the remaining families were nuclear (mean number of persons 3.90, \(SD = .47\)). Seventy-one percent of the mothers and fathers had completed a bachelor’s degree or higher. A majority of mothers were homemakers (85.7%), whereas a majority of fathers were employed in clerical/technical work or owned a small business such as a grocery shop (70.8%). The mean annual family income per person was Rupees 24821, which was higher than the average per capita for Gujarat (Central Statistical Organization, 2008).

**Measures and Procedure**

Mothers completed the Parent Response to Children’s Emotions Questionnaire in groups of 20–30, and an open-ended interview individually with a research team member. Their children completed a structured interview about emotional expression and control (results reported in Raval, Martini, & Raval, 2010).

**Parent response to children’s emotions questionnaire.** The nine hypothetical vignettes used in this measure (three each of anger, sadness, and pain) were developed based on previous open-ended interviews with Gujarati mothers and were pilot-tested in prior research (Raval et al., 2007). Sample vignettes described a sibling messing up the target child’s belongings (anger), the target child not being able to participate in a school play (sadness), and the target child experiencing a stomach ache (pain). The parent behavioral responses to these scenarios were derived from an established measure in the field, the Coping with Children’s Negative Emotions Questionnaire (CCNES; Fabes, Poulin, Eisenberg, & Madden-Derdich, 2002). Specifically, six parent behaviors from the CCNES (emotion-focused, problem-focused, solution, problem-focused: solution, expressive encouragement, punitive reactions) were included, based on its relevance in previously collected qualitative data (Raval & Martini, 2009). Based on prior exploratory research with Gujarati mothers (Pai, 1998), four maternal emotions (anger, restlessness, embarrassment, disappointment) that parents experience in response to their children’s feelings were assessed, along with parental sympathy. Mothers rated the likelihood that they would engage in each behavior or feel each emotion in the given vignette on a 7-point scale (1 = not likely, 7 = very likely).

Preliminary findings showed that three behaviors (emotion-focused, problem-focused: solution, problem-focused: explanation) were highly correlated \((r’s .44 to .88, all p’s < .001)\), and were combined to create an emotion- and problem-focused behavior composite. Three additional behaviors (punitive responses, conveying that the expression was unacceptable, and minimizing the significance of the situation) were also highly correlated \((r’s .44 to .85, all p’s < .001)\), and were combined to create a punitive and minimizing behavior composite. Expressive encouragement did not correlate well with other behaviors and was excluded from further analyses due to its low cultural relevance. In terms of emotional responses, anger, disappointment, embarrassment, and restlessness were highly correlated \((r’s .48 to .77, all p’s < .001)\), and were combined to create a negative affect composite.
Open-ended interview. During the interview, mothers were asked to describe situations in which their children had recently felt anger, sadness, or physical pain. Instructing them to keep in mind the situation/s that they described, they were asked the following questions: a) “How did you feel to see your child expressing anger /sadness /pain?”; b) “What did you do or say to your child when s/he was expressing anger/sadness/ pain?”; c) “Why did you respond in that way?”; d) “In your opinion, what should your child do when he or she is feeling angry /sad /pain?” (adapted from Gottman, Katz, & Hooven, 1996). Interviews were transcribed verbatim in Gujarati, and proficient speakers of Gujarati performed conventional content analysis that is commonly used when available research literature on a phenomenon is limited (Hsieh & Shannon, 2005). This approach is inductive and allows codes to emerge from the phenomenon is limited (Hsieh & Shannon, 2005). This approach is inductive and allows codes to emerge from the

Results

Quantitative Findings

Group differences in mothers’ reports of their emotional and behavioral responses. Mothers’ emotional responses were analyzed using a 3 (child feeling) \(\times\) 2 (mother behavior) \(\times\) 2 (child sex) \(\times\) 4 (type of psychopathology) repeated-measures analysis of variance (ANOVA), and mothers’ behaviors were analyzed using a 3 (child feeling) \(\times\) 2 (mother behavior) \(\times\) 2 (child sex) \(\times\) 4 (type of psychopathology) repeated-measures ANOVA. Child feeling (anger, sadness, physical pain), mother feeling (sympathy, negative affect), and mother behavior (emotion- and problem-focused, punitive and minimizing), were within-subject factors, and child sex and type of psychopathology (somatic complaints, internalizing, externalizing, control) were between-subjects factors. The two dependent variables were mother’s mean ratings (on 7-point scales). The Bonferroni correction was computed as \(\alpha' = .05\) per number of comparisons for each main effect or interaction. Parallel analyses with family caste, joint versus nuclear household, and mothers’ and fathers’ education as covariates revealed no statistically significant effects.

Mothers’ reports of their emotional responses. Results indicated significant main effects of child feeling, \(F(2, 114) = 27.86, p < .001, \eta^2_p = .32\); type of psychopathology, \(F(3, 112) = 7.14, p < .001, \eta^2_p = .12\); and mother feeling, \(F(1, 115) = 675.89, p < .001, \eta^2_p = .86\); which were qualified by three significant two-way interactions: child feeling \(\times\) type of psychopathology, \(F(6, 230) = 3.84, p < .01, \eta^2_p = .08\); mother feeling \(\times\) type of psychopathology, \(F(3, 115) = 13.57, p < .001, \eta^2_p = .25\); and child feeling \(\times\) mother feeling, \(F(2, 114) = 13.57, p < .001, \eta^2_p = .56\); as well as a significant three-way interaction: child feeling \(\times\) type of psychopathology \(\times\) mother feeling, \(F(6, 230) = 2.87, p < .05, \eta^2_p = .07\).

Mothers in the externalizing, internalizing, and somatic complaints groups reported more negative affect (anger, disappointment, restlessness, embarrassment) in response to their children’s anger and sadness than mothers in the control group (see Table 1). Additionally, mothers in the somatic complaints group reported less sympathy in response to their children’s anger than mothers in the other three groups, and less sympathy in response to their children’s sadness than mothers in the

Table 1

Means and Standard Deviations for Child Feeling \(\times\) Type of Psychopathology \(\times\) Mothers’ Feeling/Behavior Interaction

<table>
<thead>
<tr>
<th>Child feeling</th>
<th>Feeling/behavior</th>
<th>Externalizing ((n = 32))</th>
<th>Internalizing ((n = 31))</th>
<th>Somatic problems ((n = 25))</th>
<th>Control ((n = 32))</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Mother feeling</td>
<td>Sympathy</td>
<td>4.83(1, a)</td>
<td>1.52</td>
<td>4.85(1, a)</td>
<td>1.31</td>
</tr>
<tr>
<td></td>
<td>Negative affect</td>
<td>3.10(2, b)</td>
<td>.90</td>
<td>3.35(3, b)</td>
<td>1.20</td>
</tr>
<tr>
<td>Sadness</td>
<td>Sympathy</td>
<td>5.98(1, c)</td>
<td>1.27</td>
<td>5.76(2, c)</td>
<td>1.06</td>
</tr>
<tr>
<td></td>
<td>Negative affect</td>
<td>2.62(3, d)</td>
<td>.83</td>
<td>3.10(4, d)</td>
<td>1.12</td>
</tr>
<tr>
<td>Pain</td>
<td>Sympathy</td>
<td>5.73(1, e)</td>
<td>1.57</td>
<td>6.22(2, e)</td>
<td>1.10</td>
</tr>
<tr>
<td></td>
<td>Negative affect</td>
<td>2.27(1, e)</td>
<td>.90</td>
<td>2.87(2, d)</td>
<td>1.39</td>
</tr>
<tr>
<td>Mother behavior</td>
<td>Emotion/problem</td>
<td>5.77(1, a)</td>
<td>.80</td>
<td>5.91(1, a)</td>
<td>.93</td>
</tr>
<tr>
<td></td>
<td>Punitive/minimizing</td>
<td>5.22(2, b)</td>
<td>.95</td>
<td>4.87(2, b)</td>
<td>1.17</td>
</tr>
<tr>
<td>Sadness</td>
<td>Emotion/problem</td>
<td>6.42(1, b)</td>
<td>.76</td>
<td>6.24(2, b)</td>
<td>.71</td>
</tr>
<tr>
<td></td>
<td>Punitive/minimizing</td>
<td>4.50(3, b)</td>
<td>1.07</td>
<td>4.35(3, b)</td>
<td>1.13</td>
</tr>
<tr>
<td>Pain</td>
<td>Emotion/problem</td>
<td>6.28(1, c)</td>
<td>.83</td>
<td>6.15(2, c)</td>
<td>.74</td>
</tr>
<tr>
<td></td>
<td>Punitive/minimizing</td>
<td>3.13(3, d)</td>
<td>1.32</td>
<td>2.97(3, d)</td>
<td>1.24</td>
</tr>
</tbody>
</table>

Note. Means in the same row or column with different numerical or alphabetical subscripts, respectively, differed at \(p < .05\).
externalizing and control groups (see Table 1). A child feeling × child sex × mother feeling interaction was also found, $F(2, 114) = 3.60, p < .05, \eta^2 = .06$. Across groups, mothers reported more sympathy in response to their sons’ expressions of anger (mean $[M] = 4.82, SD = 1.19$) than their daughters’ (mean $M = 4.21, SD = 1.38; p < .05$). Mothers’ reported more sympathy in response to their sons’ and daughters’ pain (mean $M = 6.06, SD = 1.31, p < .05$), respectively; $p < .05$ than anger, and less negative affect in response to their sons’ and daughters’ pain (mean $M = 2.36, SD = 1.08$, and $M = 2.12, SD = 1.11$, respectively) than anger (mean $M = 2.69, SD = 1.23$, and $M = 2.68, SD = 1.13$, respectively, $p < .05$).

**Mothers’ reports of their behavioral responses.** Results indicated significant main effects of child feeling, $F(2, 114) = 73.81, p < .001, \eta^2 = .40$; type of psychopathology, $F(3, 112) = 9.29, p < .001, \eta^2 = .20$; and mother behavior, $F(1, 112) = 420.76, p < .001, \eta^2 = .79$, as well as three significant two-way interactions: child feeling × type of psychopathology, $F(6, 224) = 3.88, p < .001, \eta^2 = .09$; mother behavior × type of psychopathology, $F(3, 112) = 43.23, p < .001, \eta^2 = .54$; and child feeling × mother behavior, $F(2, 224) = 201.58, p < .001, \eta^2 = .64$. These main effects and interactions were qualified by a significant three-way interaction: child feeling × type of psychopathology × mother behavior, $F(6, 224) = 20.03, p < .001, \eta^2 = .35$.

Mothers in the externalizing, internalizing, and somatic complaints groups reported more punitive and minimizing behaviors toward child anger and sadness than did the control group (see Table 1). Additionally, mothers in the somatic complaints group reported less emotion-and problem-focused behaviors toward their children’s anger and sadness than all other groups; while mothers in the externalizing and internalizing groups did not significantly differ from the control group.

**Qualitative Findings**

Situations in which children experience anger, sadness, or pain. Mothers’ reports of situational antecedents support the relevance of anger, sadness, and pain for their children, and provide a portrayal of the everyday contexts in which emotion socialization occurs. Mothers indicated that anger and sadness were most commonly experienced when children were asked to behave in a way that was contrary to their wishes (e.g., being asked to study when they wanted to play, eat foods they disliked, help in the household when they did not want to, or when a desired toy could not be purchased). Other situations leading to anger included conflict with siblings or peers, and being teased or treated unjustly. Those leading to sadness included being scolded by elders, unexpected changes to recreational plans, perceived incompetence or failure in academic work, perceived lack of attention from parents, and separation from the family. With respect to physical pain, mothers reported situations including body aches, as well as common physical illnesses or injury.

**Mothers’ reported emotions and justifications.** Mothers’ descriptions of their own emotions in response to their children’s feelings were consistent with the emotions included in our quantitative measure (anger, sympathy, disappointment), but also captured the appraisals that guide these emotions. In response to children’s anger, mothers reported two predominant emotions—anger (gusso) and sympathy (sahanubhuti) — which were further distinguished based on mothers’ reasoning. For instance, some mothers indicated that they would feel angry only when their child’s anger was not justified (e.g., the child wanted to play and the mother refused because there was schoolwork to complete) or sympathy only when their child’s anger was justified (e.g., the promise to buy a desired item was not fulfilled). Other mothers did not specify conditions under which they would feel angry or sympathetic.

In response to children’s sadness, three predominant emotions reported were dukh (a unique context-dependent Gujarati emotion term referring to emotional pain, sorrow, unhappiness, grief, difficulty, or suffering, Deshpande, 1974), anger, or disappointment (mirasha), which were further distinguished based on mothers’ rationales for these feelings. Some mothers reported feeling dukh or disappointment that mirrored their child’s feeling of sadness, yet others reported dukh because the child’s sadness was perceived as an indication of the child’s failure to understand the circumstances: If the child understood the circumstances, he or she would not be sad. In contrast to anger and sadness, the primary emotions reported in response to children’s physical pain were dukh or sympathy due to the child’s suffering.

**Mothers’ reported behaviors and justifications.** Mothers’ responses to their children’s physical pain focused on finding a solution to the problem with a desire to alleviate the child’s pain. In contrast, their responses to child anger and sadness often elaborated on the culture-specific response type (problem-focused behavior emphasizing explanation) that was added to our quantitative measure. Mothers commonly reported attempts to “make the child understand” when the child was angry or sad. While some mothers did not elaborate on this strategy, others provided specific examples that included making the child understand situational constraints, family roles, the nature of emotions and emotion display rules, and the consequences of emotions. For example, one participant mother described a situation in which her son was angry because he had a fight with a friend at school. She reportedly made him understand that “getting angry does not get you anything. It impacts your health, and so he needs to learn to tolerate his anger and remain calm.” The notions that “anger is futile” and that “anger is not good for health” emerged fairly consistently. Another mother described a situation in which her daughter was sad because her younger brother took her newly purchased school materials. She reported explaining to her daughter that “her brother is young and immature. She is older and she should understand.” Here the mother is attempting to socialize her daughter about family roles and the importance of understanding with increasing age.

Some mothers also went on to describe what they would do if their primary response was not effective in making the child understand, and these secondary responses included...
scolding or spanking, or to stop talking to the child for a brief period. As one participant mother described, “If she does not understand, I would have to raise my voice. Sometimes, I may even have to give a tight slap.” Another mother described a somewhat different approach: “I stop talking for a while. That tells her that she has done something wrong, gives her some time to think. Also, this way I can calm down and later calmly explain.” The secondary responses also included coxing (e.g., making the child’s favorite food), comforting (e.g., saying that everything will be fine), or trying to distract the child. While mothers’ comforting and punitive behaviors were captured by our quantitative measure, other responses (e.g., coxing, distraction, stop talking) that seem relevant for Gujarati Indian families were not.

It is noteworthy that mothers in the internalizing, externalizing, and somatic complaints groups tended to report a vague reference to “making the child understand” without providing a specific explanation when their children were angry or sad, whereas mothers in the control group commonly provided specific examples to make their child understand. With respect to secondary responses, particularly to children’s anger, mothers in the internalizing, externalizing, and somatic complaints groups reported scolding or spanking, whereas mothers in the control group reported that they would stop talking to the child for a brief period.

Mothers’ justifications for their behavioral responses included a desire to teach the child, concern for the child’s physical or psychosocial well-being, a desire to calm the child’s emotion or ensure compliance, or a reference to the child’s immature and/or fragile character. These justifications reflected mothers’ fundamental beliefs regarding children and childhood, the nature of emotions, and how to respond to emotions. For instance, the metaphor of flowers was used to describe young children and the need to be gentle with them. As one mother explained, “He is still very young, and will understand with time. I should not be strict with him.” Another mother described that “You have to explain to the child with patience and love. If you get angry in response to the child’s anger, he will be more angry. To calm his anger, you have to show love.”

Mothers’ reported expectations for child behavior. Consistent with the overall focus on making the child understand, mothers predominantly expected that their children should adjust and accommodate to the situation when they were angry or sad. As one mother explained, “The child should not be angry. She should understand the situation, and adjust.” In contrast, when children experience physical pain, mothers expected their children to verbally communicate their feeling. Interesting group differences suggested that mothers in internalizing and externalizing groups endorsed the notion that whatever their children did when angry or sad would be acceptable because children were young and immature. For instance, one mother stated, “If the child is angry, he is going to cry or hit the other child. What else can he do?.” In contrast, mothers in somatic complaints groups endorsed the notion that nothing that the child did would be seen as acceptable because the emotions themselves were not acceptable. A mother in this group stated, “It is not good to be angry. What can be appropriate? He should just not be angry.” Control group mothers expected their children to calmly communicate their emotion. As one mother suggested, the child should, “say that I don’t like what is happening. Say it calmly.”

Discussion

The present study utilized mixed methods to study emotion socialization in children with and without behavior problems in Hindu, suburban, middle-class families in India. Information gathered from the quantitative measure demonstrated variation in mothers’ reported emotions and behaviors across groups, and these data were supplemented by an open-ended interview, the responses to which provide a broader framework for understanding emotion socialization in Gujarati families. Moreover, the open-ended interview uncovered culture-specific parent behaviors in response to child emotion that were not captured by our quantitative measure, providing a more nuanced understanding of the parent emotions and behaviors that were included in the quantitative measure.

A Framework for Understanding Emotion Socialization in Urban India

Quantitative and qualitative data indicated that Gujarati Indian mothers in our sample respond differently to their children’s emotions than their physical pain. Quantitative findings indicated that mothers report more sympathy and less negative emotion toward children’s pain than anger. Qualitative data concerning parent beliefs, behaviors, and emotions supported and further illuminated this finding. Specifically mothers reported that, when experiencing pain, children should verbally communicate their discomfort. In terms of their own responses, mothers indicated that child pain elicited solution-oriented behavior that was motivated by the desire to alleviate pain, and feelings of dukh and sympathy resulting from concern about the child’s suffering.

In contrast, mothers believed that when children experienced anger or sadness they should accept and adjust to the situation. Mothers’ emotional responses to their children’s anger and sadness included anger, sympathy, and dukh, depending on whether mothers believed the child’s emotion was justified, or whether the child had failed to understand circumstances. In terms of behavior, Gujarati mothers frequently reported attempts to make the child understand (samjha), motivated either by child-centered goals (e.g., the desire to teach something to the child, to calm the child’s emotion, to ensure the child’s long-term well-being) or parent-centered goals (e.g., ensuring compliance; see Hastings & Grusec, 1998, for a discussion of parenting goals). This response—“making the child understand”—seems to capture the essence of mothers’ behavioral responses to their children’s emotions. In ethnography of individuals in psychiatric settings in Varanasi, North India, Marrow (2005) describes the Hindi concept of samjhāna; or “making the other understand” as an attempt to alter the feeling states, cognition, and concomitant behavior of the
other. She narrates that in psychiatric wards, “most attempts at psychotherapy were described by patients and mental health workers alike as attempts to persuade and/or educate either the patient or the patient’s family member—to make the other understand” (p. 2). She further argues that this process of “making the other understand” was embedded in everyday interpersonal situations and transactions that take place in family contexts in Varanasi, and typically, the elders of the family assumed the role of making the younger members understand. Similarly, the socialization of children’s emotions in Gujarati families in the present study may be conceived in this broader context of “making the other understand.” Specifically, our qualitative data suggested that mothers wanted their children to understand that they should accept and adjust to the situation, because internalization of this important cultural value is a critical step toward the larger goal of becoming a socially interrelated person.

**Variations Across Internalizing, Externalizing, Somatic, and Control Groups**

Although mothers across groups seemed to share the broader goal of helping their children accept and adjust to the emotion-eliciting situation, and were motivated to teach, ensure compliance, or calm children’s emotion through their actions, they differed with respect to their reported emotions and behaviors to achieve this goal. Quantitative findings revealed that, in response to child anger and sadness, mothers of children in the internalizing, externalizing, and somatic complaints groups reported more negative affect (embarrassment, anger, disappointment, restlessness) and punitive/ minimizing behaviors than control-group mothers. Additionally, the somatic-complaints group showed a broad tendency to report less sympathy and emotion-/ problem-focused behaviors than all of the other groups. Although these findings appear to be consistent with the link between parental punitive/ minimizing responses and children’s internalization and externalizing problems observed in White middle-class families (Eisenberg et al., 1999; Klimes-Dougan et al., 2007; Suveg et al., 2005), a closer examination of quantitative and qualitative findings provides a more contextualized understanding of emotion socialization in Gujarati Indian families. For instance, although mothers in the internalizing and externalizing groups reported more negative affect and punitive/ minimizing behaviors than the control group, they did not differ from the control group in reported emotion-/ problem-focused behaviors or sympathy. Moreover, mothers in the internalizing and externalizing groups reported more emotion-/ problem-focused responses than punitive/ minimizing behaviors. These findings raise questions about the specific types of emotion-/ problem-focused behaviors that these mothers endorse, and how they might differ from those used by control-group mothers.

Qualitative findings indicated that mothers in the symptomatic groups tended to make more vague references to making their child understand (i.e., telling the child that s/he should understand without articulating what they should understand, or why) whereas control-group mothers tended to provide specific rationales focusing on the emotion-eliciting situation, family roles, or display rules. Moreover, mothers in the symptomatic groups tended to endorse either the notion that no behavior was acceptable when children were angry or sad (somatic complaints group) or that all behaviors were acceptable because children were young and immature (internalizing and externalizing groups). In contrast, control-group mothers specified that communicating calmly was the most appropriate child behavior when their children were angry or sad. This enhanced focus on explicit discussion may reflect the pedagogical model of child rearing described by Seymour (1999), which is a notable variation from traditional implicit socialization processes described in rural or old town communities in India (Kurtz, 1992). It may be that control-group mothers are particularly apt at recognizing and capturing the implicit cultural messages, and conveying more explicit reasoning along with their specific expectations for appropriate behavior. Such explicit reasoning may provide children with the scaffolding that is needed to both cope with the emotion and understand interpersonal situations.

Qualitative findings further showed that when their primary response (making the child understand) to child anger was ineffective, mothers in the symptomatic groups reported scolding or spanking, whereas mothers in the control group reported that they would stop talking to the child for a brief period. Informal reports from Gujarati adults indicated that this disciplinary method was common, and control-group mothers reported that it provided children with some time to think about what they had done, while also giving mothers time to calm down and think about what to do. Perhaps for control-group mothers, this behavior serves as a psychological time-out in which one removes oneself psychologically from the social context, while remaining physically present (in contrast to the Western concept of behavioral time-out in which the child is physically removed from the situation). Further research is needed to closely examine the meaning and implications of this behavior in Gujarati Indian culture.

Though child gender was not a central variable in the current study, our quantitative findings indicated that mothers reported less sympathy toward their daughters’ expressions of anger than their sons’. Hindu folk theories (Menon, 2000) have indicated less acceptance of anger in women than men, which makes sense in the context of differential socialization goals for girls and boys. Girls are traditionally socialized so that they can accommodate to the lifestyles of their husband’s households upon marriage, and also carry the pressure of upholding the highest moral standards for the rest of the society (Menon, 2000). Future studies should further examine the contribution of parent and child gender in emotion socialization in India.

**Limitations and Future Directions**

Our quantitative measures were pilot-tested, standardized, data-driven, and supplemented by open-ended interviews, although the constructs examined were derived from
Western psychological literature. Future examinations of adult concerns about child behavior problems in local terms may enrich the understanding of youth well-being in India. Given that caregiving in India is traditionally socially distributed, inclusion of the perspectives of a wide range of caregivers (e.g., fathers, grandparents, uncles, aunts) that Indian children interact with in their daily lives, and the use of observational methods would provide a more comprehensive assessment of emotion socialization. Moreover, comparative studies of maternal socialization in Gujarati Hindu and other cultural groups, as well as an examination of within-culture variation (e.g., the role of child gender, nuclear vs. joint family structure, caste, socioeconomic status), are needed to examine the full range of cultural models of emotion socialization. Finally, we examined mothers’ reports of emotion socialization and child behavior problems at a single point in time, which makes it difficult to ascertain whether maternal socialization patterns preceded the occurrence of behavior problems, or whether difficult child behaviors elicited those parental responses. Longitudinal studies that incorporate prospective measures of maternal socialization and child behavior problems in Gujarati culture are needed to establish direction of effect.

Despite these limitations, the present study makes an important contribution to a culturally informed theory of emotion socialization, and to understanding socialization practices in Hindu urban middle-class families in India, a country with the world’s second largest population. Qualitative findings provide insight into culture-specific socialization goals and behaviors and demonstrate that there may be constructs that are relevant to other cultures (e.g., making the child understand in response to emotions) that have not been studied in Western samples. Both quantitative and qualitative findings converge in demonstrating that patterns of socialization vary across children with behavior problems, and those who are asymptomatic. In the long run, these findings may help to inform the development of culturally sensitive, family-based interventions for child behavior problems in India.

References


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**Correction to Raval and Martini (2011)**

The article “Making the Child Understand: Socialization of Emotion in Urban India,” by Vaishali V. Raval and Tanya S. Martini (*Journal of Family Psychology, Advance online publication. August 29, 2011. doi:10.1037/a0025240*) contained a production-related error. In the third paragraph of the Discussion section, the words *samjha avavu* and *samjha ana* were misspelled as *samjh avavu* and *samjh ana*. All versions of this article have been corrected.

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