EMOTION AND CULTURE

EMPIRICAL STUDIES OF MUTUAL INFLUENCE

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CHAPTER 10

Culture, Emotion, and Psychopathology

Janis H. Jenkins

This chapter contributes an anthropological examination of the nexus among culture, emotion, and psychopathology. The first section is a brief introduction to current approaches to the topic. The second section is a critical appraisal of two conceptual issues underlying these approaches, namely the distinctions between normal and pathological emotion and between feeling and emotion. The validity of these distinctions is called into question through presentation of an ethnographic case. The third section is a brief review of issues surrounding studies of emotion and particular major mental disorders (schizophrenia and depression). Finally, I suggest new directions for studies of emotion based on intersubjective dimensions of culture and experience, as a step beyond cognitive–linguistic and ethnopsychological studies of emotion.

I begin by providing an orientation to the constructs of culture, emotion, and psychopathology. For culture, I draw on a recent definition

by Jenkins and Karno (1992):

> Culture can be defined as a generalized, coherent context of shared symbols and meanings that persons dynamically create and recreate for themselves in the process of social interaction. In everyday life, culture is something people come to take for granted—their way of feeling, thinking and being in the world—the unselfconscious medium of experience, interpretation, and action. Culture is thus the most generalized baseline from which individuals may deviate,[1] and hence invaluable for comparative studies of psychopathology. (p. 10)

Culture is therefore not a variable that can be operationalized for use in research protocols; culture is a complex context through which all human experience and action—including emotions—is interpreted (Geertz, 1973). In addition, culture is best conceived as a dynamic process that may be contested by diverse cultural members. In this emergent and processual sense, culture is neither static nor monolithic. As recently argued by White and Lutz (1992), the notion of culture as neither contested nor historically grounded is of limited use.

Although emotion is by no means absent in classic ethnographies (Bateson, 1958; Benedict, 1934; Hallowell, 1955; Mead, 1935), explicit interest in this topic has occurred as the result of a paradigm shift in conceptualizations of emotion. Rather than presuming emotion as a psychobiological universal, emerging anthropological theories of emotion have instead posited emotion as inherently cultural (Geertz, 1973; Lutz, 1982, 1988; Rosaldo, 1980, 1984). Consider Rosaldo's anthropological conceptualization of emotion as

> self-concerning, partly physical responses that are at the same time aspects of moral or ideological attitudes; emotions are both feelings and cognitive constructions, linking person, action, and sociological milieu. Stated otherwise, new views of culture cast the emotions as themselves aspects of cultural systems, of strategic importance to analysts concerned with the

[1]For a theoretical discussion of culture and deviance (including psychopathology), see Edgerton (1985). For a review of a controversial thesis concerning the notion that widespread or institutionalized forms of deviance (including psychopathology) may constitute a "sick society," see Edgerton (1992).

> ordering of action and the ways that people shape and are shaped by their world. (Levy, 1983, p. 128)

Identification of the specifically cultural nature of emotion has led to a proliferation of anthropological studies (Abu-Lughod, 1986; Abu-Lughod & Lutz, 1990; Desjarlais, 1992; Gaines & Farmer, 1986; B. Good & Good, 1988; Hollan, 1988; Jenkins, 1991b; Kitayama & Markus, chapter 1, this volume; Kleinman & Good, 1985; Lutz, 1985, 1988; Lutz & Abu-Lughod, 1990; Lutz & White, 1986; Mathews, 1992; Myers, 1979; Ochs & Schieffelin, 1987; Rosaldo, 1980; Roseman, 1990; Scheper-Hughes & Lock, 1987; Schieffelin, 1983; Shweder & LeVine, 1984; Wellenkamp, 1988; Wikan, 1990). These studies have provided extensive ethnographic evidence that emotional experience and expression differ cross culturally. In addition, these ethnopsychological studies of emotion examine factors such as notions of the self, indigenous definitions and categories of emotion, salience of particular emotions within sociocultural settings, interrelations among diverse emotions, contextual identification of those situations in which emotions are thought to occur, and ethnophysiological accounts of the bodily experience of emotion (Jenkins, Kleinman, & Good, 1991).

Because the ethnographic record provides compelling evidence that emotional expression differs cross culturally, it follows that we can expect emotional disorders to be manifest in culturally distinctive ways as well. Thus, the cross-cultural validity of diagnostic categories of psychopathology is the subject of controversy (Kleinman, 1988a; Kleinman & Good, 1985; Manson, Shore, & Bloom, 1985). At issue is the extent to which symptoms and syndromes described in the revised third edition of the American Psychiatric Association's (1987) *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–III–R*) are appropriately used in clinical and research assessments of groups other than those for whom it was empirically derived (i.e., Euro-American populations). It is possible that the form, content, and constituent components of a given syndrome may vary across cultural groups. Indeed, Kleinman (1987) cautioned that failure to analyze *DSM* categories critically in cross-cultural research may result in a *category fallacy*. "A category fallacy is the reification of a nosological category developed for a particular cultural group that is then

applied to members of another culture for whom it lacks coherence and whose validity has not been established" (Kleinman, 1987, p. 452). While acknowledging the widespread agreement among psychiatric anthropologists that the *DSM* categories are grounded in cultural conventions, B. Good (1992a) advanced a compelling argument for the productive use of specific *DSM* categories—rather than generalized distress—as a starting point for comparative research. By submitting the *DSM* categories to cross-cultural analysis, the cultural conventions on which they are based—including indigenous definitions of normal (and abnormal) behavior, variations in the experience and expression of emotion and self, and culturally informed assessments of what constitutes distressing life circumstances[2]—are brought to light. In addition, diagnostic criteria on the basis of thresholds for symptom severity and duration should also be cross culturally scrutinized.

Current Anthropological Approaches

Current approaches to culture, emotion, and psychopathology can be summarized within the following interrelated domains of inquiry: (a) studies from psychological anthropology of the cultural constitution of emotion and self; (b) studies from medical anthropology of dysphoric affects and affective disorders; (c) phenomenological accounts of the body as a generative source of culture; (d) sociopolitical analyses of emotion; and (e) experiential accounts of dysphoria and suffering. I will briefly summarize selected relevant works from each of these areas.

Emotion topics studied by psychological anthropologists include cross-cultural variations in the experience and expression of emotion (Briggs, 1970; Edgerton, 1971; Levy, 1973; Myers, 1979; Roseman, 1990; Schieffelin, 1983; Shweder & LeVine, 1984; Wikan, 1990); the cultural constitution of the self (Csordas, 1993; Hallowell, 1955; Marsella, DeVos, & Hsu, 1985; Shweder & Bourne, 1984; Stigler, Shweder, & Herdt, 1990; White & Kirkpatrick, 1985); the socialization of emotion (Clancy, 1986; LeVine, 1990; Ochs & Schieffelin, 1987; Weisner, 1983); linguistic studies of emotion (Beeman, 1985; Lutz, 1988; Ochs & Schieffelin, 1987); cognitive studies

[2]For further discussion on this point, see Karno and Jenkins (in press) and Jenkins and Kinzie (in press).

of emotion (D'Andrade, 1987; Holland, 1992; Lakoff & Kovecses, 1987; Lutz, 1982; Mathews, 1992; Solomon, 1984; White & Kirkpatrick, 1985); and theoretical analyses of the emotion construct in Western scientific discourse (Lutz, 1988; Lutz & Abu-Lughod, 1990; Rosaldo, 1984).

Medical and psychiatric anthropologists have provided cultural analyses of dysphoric affects and affective disorders. Studies in this area have been advanced in recent years with the advent of "the new cross-cultural psychiatry" by Kleinman (1977) and "meaning-centered medical anthropology" by Byron Good and Mary-Jo DelVecchio Good and colleagues (1982). Prior to Kleinman's introduction of a revised approach to cross-cultural psychiatric research, the guiding paradigm of universalism and culture as important to the content but not the form or process of psychopathology held sway. This produced a rather static state of academic affairs until the new cross-cultural psychiatry revolutionized the field. Several new anthropological questions have been advanced: (a) To what extent does the course and outcome of psychiatric disorders differ cross culturally? (b) Is there a tacit model in cross-cultural psychiatric research that exaggerates the biological dimensions of disease and deemphasizes the cultural dimensions of illness? (c) What place does translation have in cross-cultural research? (d) Does the standard approach to cross-cultural research in psychiatry commit a category fallacy? (Kleinman, 1987, pp. 448–452). Meaning-centered medical anthropology, introduced by B. Good and Good (1982), has also led the field through an interpretive approach to questions of cultural meaning that invariably constitute illness experience. With regard to the question of cultural translation, for example, B. Good and Good (1988) observed that

> the referents of symbols—i.e., their meaning—are aspects of a culture or a life world, not objects outside of language through which language obtains meaning. "Heart distress" for Iranians is not the equivalent of "heart palpitations" for Americans; it does not *mean* the same thing (cf. B. Good, 1977). It is a symbol which condenses a distinctive set of meanings, a culture-specific semantic network. (p. 14)

Topics in the area of the new cross-cultural psychiatry and meaning-centered medical anthropology are by now vast and include cultural meanings and indigenous definitions of distress and disorder (Gaines & Farmer,

1986; B. Good, 1993; B. Good & Good, 1982; Guarnaccia, Good, & Kleinman, 1990; Jenkins, 1988a, 1988b; Kirmayer, 1989; Low, 1985; Lutz, 1985; Tousignant, 1984); culture-bound "syndromes" (Carr & Vitaliano, 1985; Simons & Hughes, 1985); the cultural validity of *DSM–III–R* categories cross culturally (Gaines, 1992; B. Good, 1992a; B. Good, Good, & Moradi, 1985; Hopper, 1991; Kleinman, 1980, 1986, 1988a; Manson et al., 1985); affective styles and the course of mental disorder (Corin, 1990; Jenkins, 1991a; Jenkins & Karno, 1992; Karno et al., 1987); the epidemiology of affective disorders cross culturally (Beiser, 1985; Guarnaccia et al., 1990; Manson et al., 1985); and critiques of medicalized representations of distress and suffering in Western scientific discourse (Fabrega, 1989; Kleinman, 1988b; Kleinman & Good, 1985; Scheper-Hughes & Lock, 1987).

Another current approach to the study of culture, emotion, and psychopathology is rooted in phenomenological accounts of embodiment (Csordas, 1990, 1993; Frank, 1986; B. Good, 1992b; Kleinman, 1986; Ots, 1990; Scarry, 1985). One aspect of this approach is conceptualization of the body as a generative source of culture (Csordas, 1993). Such approaches move beyond mentalistic and representational studies of culture as located "from the neck up."[3] Often the body is relegated to the role of an object upon which cultural meaning is imposed or "inscribed." Recognizing that meaning presupposes embodiment also means more than that the body is a source domain for image schemas and other mental representations (Lakoff & Kovecses, 1987). It means shifting the conceptualization of culture away from emphasis on symbol, structure, propositions, or schema to emphasis on sense, orientation, gesture, and habit. Foregrounding embodiment in cultural analysis brings out the immediacy of emotion (Scheper-Hughes & Lock, 1987) and problematizes the distinction between subject and object (Csordas, 1990, 1993; Ots, 1990). Another contribution of this literature is to highlight (a) the distinction between body as representation and as being in the world (Csordas, 1990), and (b) the existential ambiguity or indeterminacy underlying categories

[3]I owe the characterization of the restricted relevance of culture as primarily "from the neck up" to Csordas (1990, 1993) from his work on culture and embodiment in medical and psychological anthropology.

like intuition, imagination, perception, and sensation in relation to emotion (Csordas, 1993).

A fourth area is the sociopolitical analysis of emotion. Theorizing by B. Good and Good (1988) on culture and emotion has taken a new direction in attempting to account for the force exerted by the nation-state in producing emotional tones, sentiments, and actions within a society. They urge examination of "the role of the state and other political, religious, and economic institutions in legitimizing, organizing, and promoting particular discourses on emotions" (p. 4). Lutz and Abu-Lughod's (1990) analysis of the interplay of emotion talk and the politics of everyday social life has also redirected scholarly attention away from largely privatized and culturalized representations of emotion to examination of emotion discourse in the contexts of sociability and power relations. Kleinman's (1986) case studies from China convincingly demonstrated the social and political production of affective disorders in China. However, analysis of the mental health sequelae of the profound sociopolitical change has scarcely begun (Farias, 1991; Jenkins, 1991b; Mollica, Wyshak, & Lavelle, 1987; Suarez-Orozco, 1989; Swartz, 1991; Westermeyer, 1989).

Emphases on sociopolitical aspects of affectivity expands the parameters of emotion theory beyond those previously conceived as primarily biological, psychological, or cultural. Much of this current thinking is explicitly or implicitly embedded in feminist theory that has long been concerned with power relations and inequities in social worlds, both personal and public (Rosaldo & Lamphere, 1974). Feminist analyses also question the limits of cultural relativism through grounded locational perspectives on human experience and the human condition (Haraway, 1991). The emerging agenda for studies of emotional processes and experience must therefore take political dimensions into account of intentional worlds large and small.

A final area for advancing emotion theory centers around the concept of experience (Hallowell, 1955; Kleinman & Kleinman, 1991; White & Kirkpatrick, 1985; Wikan, 1990). According to Kleinman and Kleinman (1991), experience can be defined as

> an intersubjective medium of social transactions in local moral worlds. It is the outcome of cultural categories and social structures interacting with

> psychophysiological processes such that a mediating world is constituted. Experience is the felt flow of that intersubjective medium . . . in practical terms, that mediating world is defined by what is vitally at stake for groups and individuals. (p. 277)

The need to focus attention on experiential dimensions of emotion is critical because an understanding of ethnopsychological categories, though important, is insufficient. Kleinman and Kleinman (1991) argued that, in the absence of experientially based accounts of emotion generally, and suffering in particular, social scientific categories (not unlike those from medicine) do not adequately represent (and indeed may seriously distort) human worlds of suffering. This critique can apply to any of an array of prevailing social science concepts that homogenize or romanticize some of the more complex and subtle dimensions of psychocultural worlds. For example, Kleinman and Kleinman critiqued ethnographic characterizations of the self as sociocentric in many non-Western societies as being not fully adequate.[4]

Whereas previous anthropological theory may have been quick to endorse the assumption of the fundamental universality of emotional life in each of the above five areas of inquiry, contemporary approaches are more likely to be concerned with cultural specificity and situatedness. The new emphasis calls into question essentialist[5] claims of basic, universally shared emotions that are based upon innate, uniform, biological processes. Such notions of stratigraphic levels, where "brute, precultural fact" is bedrock have been critiqued by cultural anthropologists (Geertz, 1973). These presumably more fundamental and somehow "pure" biologic realities have long been awarded analytic primacy by many psychologists

[4]See Kleinman and Kleinman (1985, 1991) and Kleinman (1986) for illustrative case examples from China following the Cultural Revolution. For individual variability of emotion within cultural contexts, see Edgerton (1971) and Shostak (1983).

[5]Essentialist approaches seek to confirm notions regarding essential, pan-human, underlying human characteristics and processes. A principal problem of essentialist approaches is an empirically unexamined readiness to assume the similarity, regularity, and homogeneity of human phenomena. As such, the appreciation of another order of "inherent" qualities such as diversity, irregularity, and heterogeneity may be sacrificed. Essentialist approaches have been critiqued as reductionistic and overinclusive, imposing order where nonuniform and unpatterned "characterizations" might better suit. Lutz and Abu-Lughod (1990) and Kirmayer (1992) provided excellent discussions of the problems generated by essentialist presumptions.

who endorse natural science paradigms for the study of emotion (Rosaldo, 1984). The psychological research of Plutchik (1980) exemplifies this approach:

> Although there is nothing like a consensus as yet on definitions, psychology may well come up with some system of describing the basic elements of personality—the emotions—that will be the equivalent in impact on behavioral science as Mendeleyev's period table in physics or Linnaeus' system of classifications in biology. (p. 78)

As indicated above, current anthropological views of emotion are not inclined toward natural science models as the most productive means for conceptualizing or investigating the key research questions.

Conceptual Distinctions in Anthropological Studies of Emotion and Psychopathology

We turn our attention now to consideration of two conceptual issues surrounding the distinctions between (a) normal and pathological emotion, and (b) emotion and feeling. These distinctions and their inherent problems are fundamental to current studies of culture, emotion, and psychopathology.

First is the distinction between *normal* and *pathological* emotion: If we consider normal emotions to be those commonly shared within a given community, are abnormal emotions those outside the range of normal human experience within that setting? Are concepts of the normal and the pathological better conceived as discontinuous categories or as poles on a continuum? Are there distinct qualitative differences between a normal emotion and a pathological state? Could a qualitative continuum between happiness and sadness, for instance, be contrasted with clinical mania and depression at the pathological extremes of the continuum? Is abnormality to be defined in quantitative terms as simply "more" of what otherwise might fall within the parameters of normal experience? In the case of the *DSM–III–R* (American Psychiatric Association, 1987), specific symptoms are organized quantitatively according to severity, duration, and co-occurrence with one or more other symptoms that comprise a particular syndrome. According to psychiatric diagnostic procedure, emo-

tions are abnormal if they are severe, are prolonged, and co-occur with other behavioral or cognitive symptoms.

The second conceptual distinction concerns the relationship between feeling and emotion. Thus, although there is a developing consensus among psychologists that even the subjective component of emotion is constructed (Ellsworth, chapter 2, this volume; Frijda & Mesquita, chapter 3, this volume), it is still common to assume that there is some basic and irreducible aspect of emotion. One way in which this problem is manifest is in the distinction between (biologically sensation-based) feeling and (culturally interpreted) emotion. Frijda (1987) has identified what makes physical feelings particularly affective:

> "Elementary feelings" differentiate affective from nonaffective experience in that they presuppose some object the feeling is about. That is, they have the property of subjectivity: They are experienced as one's own subjective response, rather than ascertain a property of the object. They are evaluative: They imply acceptance or nonacceptance of the stimulus or of the experience itself.... They cannot be localized in space; they cannot be objectified, that is, referred to stimulus properties.... They are evanescent when attention is directed upon them. (p. 179)

Thus, both feelings and emotions can be placed under the broad class of affect. The issue here, much contested at the turn of the century by introspectionists, concerns whether feeling should or should not be considered to be a distinct class of experience (Frijda, 1987, pp. 179–180). According to Wundt (1903) and Titchener (1908), feelings are a basic, irreducible kind of mental element that cannot be analyzed in terms of other kinds of mental elements, sensory sensations, and images (and thoughts). If for them feelings were distinct as mental acts, the contemporary distinction tends to construe their nature more as physical in contrast to the mental nature of emotion. The consequences are two: (a) Feelings are understood to be biological, whereas emotions are understood to be cultural; and (b) because they are biological, feelings are understood to be universal and immutable, whereas emotions are understood to be cross-culturally variable. Because they are immutable, feelings are no longer problematic, and attention is devoted to emotion defined as cultural, cognitive, and interpretive. This biologization, universalization,

and ultimately exclusion of feeling thus has remained problematic. It may prove to be more productive to collapse this distinction at the outset and to define emotion as necessarily both a physical response *and* a cognitive construction (Rosaldo, 1984).

Cultural Realms of Pangs, Vapors, and Twinges: An Ethnographic Account of *El Calor* (the Heat) Among Salvadorans

I am not convinced that feelings and emotions are neatly separable; nor am I convinced that as a basically irreducible emotion element, feelings are primarily biologically based. Dichotomous presumptions of the cultural as mental and the bodily as biological have deemed the sensate realm of pangs, vapors, and twinges as unimportant to culture theory, considering them instead as largely unelaborated by cultural–linguistic symbols. Recent conceptualizations of the body as a wellspring of culture, experience, and engagement in the world may counterbalance more cognitive approaches to culture that emphasize the study of mental representations (e.g., knowledge, schemes, and discourse) as the centerpiece of culture. When both feelings and emotions are recognized as cultural, their relationship, indeed the very distinction between them, becomes problematic.

Here, we introduce what we found to be an illuminating example from ethnographic–clinical work with Salvadoran women refugees seeking help at an outpatient psychiatric hospital in Cambridge, Massachusetts.[6] The women offer three principal reasons for their flight from El Salvador: escape from large-scale political violence, escape from domestic violence,[7] and escape from impoverished economic conditions (Jenkins, 1991b). At the time of entry into the study, nearly all the women reported symptoms of affective and posttraumatic stress disorders (PTSD). Among a diverse set of culturally specific bodily phenomena reported by the

[6]This research was conducted collaboratively with colleague Martha E. Valiente, a clinical psychologist specializing in the treatment of this population. For a fuller description of *el calor* than can be provided here, see Jenkins and Valiente (in press).

[7]Regular, so-termed *domestic* violence and abuse are the bodily experience of many of the Salvadoran women refugees in the study. Indeed, some of them cited escape from abusive husbands and fathers as a principal reason for migrating from El Salvador.

women, *el calor* (the heat) stood out as a particularly salient form of bodily experience. Accounts of personal experience with *el calor* were offered either spontaneously during the course of the interviews or in response to direct queries.[8] Although "heat" has been reported as central to depressive experience in some cultural settings (Ifabumuyi, 1981), heat is not represented in the *DSM* symptom profiles of depression or of PTSD.

El calor is the experience of intense heat that may rapidly spread throughout the entire body. It sometimes emanates from the head (e.g., face, ears, nose, and mouth, including taste and breath), neck, back, leg, stomach, chest, and hands. Such body sites are often described as a focal point of *el calor*. Although *el calor* occurs within one's body, it invades from without. It may be brief (momentary) or prolonged (continuous for days). Although some women narrated experiences of *el calor* as both infrequent and largely insignificant, others' more frequent bouts with it were often described as insufferable. *El calor* was observed among women aged 25–56 years (Jenkins & Valiente, 1994).

What are the relevant criteria for defining the emotions surrounding *el calor* as normal or abnormal? In our view, the wide array of symptomatic distress commonly observed among refugees is arguably a normal human response to abnormal (i.e., pathological) human conditions. This is so because sustained exposure to sociopolitical turmoil in the context of war-related violence or terror is likely to produce such emotional distress in nearly anyone. Such distress is culturally patterned and sociopolitically produced in ways that may have relatively little to do with individually based patterns of response or adaptation (Jenkins & Kinzie, in press).

Emotion words associated with strong experiences of *el calor* include *miedo*, *temor*, *susto*, and *preocupaciónes* (fear, dread, fright, and worry); *desesperación* (despair/desperation); *agonía* and *muerte* (agony, death), and *coraje*, *enojo*, *enfado* (anger).[9] Tropes for *calor* include similes

[8]Thanks to Jeff Jacobson and Maria-Jesus Vega for research assistance in the transcription and data analyses of the interview materials.

[9]Emotion terms in Spanish here are not readily translated into English. The English-language terms with which the Spanish emotion words are juxtaposed can only be considered general glosses, but by no means precise equivalents. As for *song* among the Ifaluk, an emotion that includes both anger and sadness (Lutz, 1988), *calor* is unrecognizable as a primary Euro-American ethnopsychological domain because it incorporates an unfamiliar range of both anger and fear.

and metaphors such as *vapor* (vapor), *corrientes* (electrical currents/surges), *fuego* (fire), or *llama* (flame). For instance, *un vapor* (a vapor) is a sort of steam heat that may begin in the feet and quickly rise up to the head. Although intense, *el calor* may also have an insubstantial, momentary quality that soon dissipates from the body. Therefore, *un vapor* is a representation of a type of incarnate substance.

Although it is true that *el calor* is a cultural experience for Salvadorans, it is only a partially objectified one. This indeterminacy is evident in the linguistic ambiguity over how best to refer to *el calor*. For example, some women used the term readily, whereas a few claimed no familiarity with it. Nevertheless, those women who did not directly use the term *el calor* typically went on to narrate experiences that are not readily distinguishable from those women who made common mention of it. Some women preferred relatively straightforward descriptions of *el calor*; others shifted freely between metaphor and simile to convey a strong, yet apparently elusive, bodily experience (Jenkins & Valiente, 1994).

Common situations in which *el calor* is experienced include threats to one's physical integrity, such as ongoing civil warfare, impending domestic violence, family conflict, or life-threatening illness. However, aside from these more serious situations, *el calor* also occurs in everyday, mundane circumstances in which no conflict or immediate threat is apparent. Some contexts that evoke this response may be culturally specific (as in situations in which one interprets a particular action as a grave challenge to one's status or security). In other contexts, one might hypothesize that there are cross-culturally similar shared features that evoke the primordial fight or flight response.

How then is *el calor* better conceptualized: as a feeling or as an emotion? We wonder whether this very distinction is predicated on the traditional dualist idea that *the closer we come to the body, the farther away we must be from culture*. With *el calor*, however, we do not have the simple situation of an inchoate feeling that is culturally made over into an emotion by being framed, interpreted, elaborated, and objectified. Rather, we have what might appear to be an intermediate phenomenon, one that is sometimes identified and labeled, but as a feeling rather than as an emotion. Does this mean that it is not yet an emotion? Or does it

mean that our distinction between feeling and emotion is overdrawn? Cross-cultural studies of emotion categories frequently demonstrate that the emotional world is carved up differently, with observations of the sort that different emotion concepts do not map directly onto our own. *El calor* is a category of a different order. It is not correct merely to say that it does not directly map onto English-language distinctions between anger and fear. It incorporates these as a bodily metaphor, sometimes blending both, sometimes inarticulate, and sometimes evoking the response "of course I was angry/afraid." From the standpoint of the lexicon of emotion words, the important observation is not that *el calor* fails to distinguish between anger and fear and therefore must be considered to be subemotional. Instead, one can as easily conceive of *el calor* as *meta-emotional*, a concept that merges the physicality of the socially informed body and the mentality of a culturally constituted self, the evanescence of feeling and the communicability of emotion, the intimate relation between anger and fear, and the primordial "fight or flight" response. It is less correct to say that a person felt *el calor* and had the emotion of fear than it is to say that *el calor* is an emotion—a bodily one, yet no less cultural than any other.

To make a general conclusion, I point out the consequence of distinguishing between biological feeling and cultural emotion in the domain of psychopathology. Here, the distinction is nothing less than the condition of possibility for the concept of somatization of emotion. If feelings are somatized emotions or if emotions are psychologized feelings, a conceptual problem exists. But in the debate about psychopathology, it is typically implied that emotions are somehow more pure, and somatized emotions are distorted or masked forms of this pure experience. The distortion or masking connotes pathology in itself—thus feelings are implicitly pathological by nature.

Thus, the conceptual and methodological separation of feeling, emotion, mood, and disorder remains problematic. There can be no neat boundaries among these diverse emotion realms (Kleinman & Good, 1985). Moreover, the problematic nature of distinctions between emotion and illness extends beyond scientific to popular contexts as well. Popular ethnotheories place emotion on a continuum between lesser

amounts that are proper, healthy, or normal, and greater degrees of emotion understood as socially or spiritually dangerous and potentially illness-engendering. In Latin American ethnopsychologies, for example, the personal experience of anger or fear, whether caused by intimate or unknown sources,[10] often poses serious dangers to one's health (Jenkins, 1988b, 1991b).

Studies of Emotion and Major Mental Disorder: Schizophrenia and Depression

Both schizophrenia and depression incorporate a wide range of cognitive, behavioral, and affective symptoms. Thus, it seems somewhat arbitrary that schizophrenia is often conceived as a thought disorder and depression as an affective or mood disorder. Both disorders are affectively mediated with regard to culture and to (a) symptomatic expression and (b) the course and outcome of an illness. This section briefly reviews these issues in light of longitudinal evidence from the World Health Organization's (WHO; 1979) International Pilot Study of Schizophrenia (IPSS): Ibadan (Nigeria), Cali (Colombia), Agra (India), Aahras (Denmark), Washington, DC (United States), London (England), Moscow (Russia), Prague (Czechoslovakia), and Taipei (China). Studies of family expressed emotion (Brown, Birley, & Wing, 1972) are also summarized.

Schizophrenia, regarded by contemporary psychiatry as the most biogenetic of disorders, is noteworthy for its considerable heterogeneity of manifestation. Although some of this variation may be biologically produced, the patterned variation in symptoms such as hallucinations, delusions, social withdrawal, and *flat affect* provide powerful cross-cultural evidence of an important role for culture in mediating symptomatic expression. Although any of the symptoms might arguably be considered affective, flat affect is of special interest here. Flat or blunted affect, often thought of as pathognomonic of schizophrenia, has been defined as "a disturbance of affect manifested by dullness of feeling tone" (Freedman, Kaplan, & Sadock, 1976, p. 1280). For example, a common situation in

[10]Each of these (intimate or unknown sources) may be perpetrated by means of witchcraft.

which flat affect might be manifest is the failure to express appropriate emotion upon hearing the news of the death of a beloved family member. The clinical belief is that a person with schizophrenia may either fail to register any emotional response or may respond inappropriately (e.g., with laughter).

The WHO IPSS symptom profiles reveal that patients from the more industrialized research sites (Moscow, Aarhus, Taipei, and Prague) were more likely to have been rated positively for flat affect. In addition, a wide range of flat affect was found for the IPSS sample: 8% in Ibadan as compared with 50% in Moscow (WHO, 1979).[11] On the other hand, the average percentage of flat affect across all research centers was only 24%, a figure that might be considered low for a symptom often touted as pathognomonic for schizophrenia (Bleuler, 1950).

In light of the above general review on the relationship between culture and emotion, it is to be expected that what constitutes flat or inappropriate affect in Society A cannot be considered directly equivalent to that observed in Society B or C. Given this observation, it is troubling that the IPSS investigators neglected to report on the cross-cultural validity of their comparative assessments.[12] This problem is made all the more salient in light of the overall low frequency of flat affect and the concomitant finding that it was the second most common symptom observed at follow-up.[13]

[11]The differences between the nonindustrialized and the more industrialized countries are not uniform, however; only 9% of London patients and 11% of Washington patients displayed flat affect at follow-up.

[12]Apart from the cultural issues surrounding the display of affect across different settings, a different point concerns the fact that surface displays of flat or inappropriate affect may belie an underlying and everyday "sustained terror" commonly reported by persons who experience schizophrenic states (Glass, 1989).

[13]The rating of "lack of insight" as the most common symptom may represent a clash between professional psychiatric formulations of the problem (in cultural categories that feature psychiatric, nervous, or mental problems) and popular illness categories that may conceptualize the problem more broadly to include spiritual or supernatural, socioeconomic, or nonindividualized understandings. Another major difference is a tendency among persons of little formal education not to "psychologize" illness but rather to experience and express their illness in culturally elaborated bodily terms (e.g., physical sensations, total body experience). In this regard, the IPSS failure to appreciate these cross-cultural differences anthropologically in what Kleinman (1980) termed "explanatory models" has likely resulted in an ethnocentric representation of the most frequently reported symptom in the IPSS follow-up data.

An issue that has yet to receive adequate attention concerns the contribution of individual symptoms to course and outcome. According to the IPSS (WHO, 1979), different symptoms predict different outcomes across the various research centers. These findings appear to provide strong evidence for the contextual specificity of particular sociocultural and clinical features that mediate the course of schizophrenia cross culturally. The Western prognostic expectation is that affective symptoms are associated with a good outcome and flatness of affect with a poor outcome. This general expectation is not uniformly endorsed by the IPSS findings: only in Agra, Ibadan, and Moscow was flat affect among the five best predictor variables. This leaves much of the sample outside the reach of standard clinical expectation concerning the prognostic associations for flat affect.

Two-year follow-up data from the WHO IPSS on 1,202 patients from nine nations provide the basis for the well-known conclusion that "on virtually all course and outcome measures, a greater proportion of schizophrenic patients in Agra (India), Cali (Colombia), and Ibadan (Nigeria) had favorable, nondisabling courses and outcomes than was the case in Aarhus, London, Moscow, Prague, and Washington" (Sartorius, Japlensky, & Shapiro, 1978, p. 106). The better outcome for schizophrenia in developing countries relative to the more industrialized nations led the IPSS to conclude that "one could consider the social or cultural environment as the possible key to understanding the observed differences in course and outcome between developing and developed countries" (Sartorius et al., 1978, p. 111). In particular, the IPSS investigators hypothesized that family and community response to the illness may provide a central link among culture, emotion, and the course of schizophrenia.

Emotions expressed by family members toward an ill relative have been found to be significant to the course and outcome of schizophrenia. Indeed, substantial evidence from the *expressed emotion* psychiatric research paradigm has established that the course of schizophrenia varies in relation to kin affective response (Brown et al., 1972; Karno & Jenkins, in press; Karno et al., 1987; Vaughn & Leff, 1976; Vaughn, Snyder, Jones, Freeman, & Falloon, 1984). Hypotheses for why this is so have generally focused on a pronounced sensitivity (or extra-sensitivity) and respon-

siveness to the social–affective environment (Vaughn & Leff, 1976). Although both positive (e.g., warmth) and negative (e.g., hostility) emotions have been investigated, several studies have been replicated that identify three affective responses with a poor course of illness: anger and hostility (expressed though criticism) and emotional overinvolvement (expressed in unusually self-sacrificing, overprotective, or intrusive behaviors on the part of close relatives).[14]

Theoretical issues surrounding the expressed emotion research require further attention. These include questions on the nature and meaning of the construct and its cultural validity for use in comparative research. A cross-culturally informed review of expressed emotion studies was provided by Jenkins (1991a) and Jenkins and Karno (1992). As Jenkins and Karno (1992) argued, the fact that the expressed emotion factors are substantially cultural in nature has yet to be fully appreciated. Although these authors have provided an outline of diverse cultural, psychobiological, and social–ecological features of expressed emotion, they argue that the expressed emotion construct is tapping primarily into cross-culturally variable features of family response to an ill relative. Specifically, the cross-cultural variance occurs in relation to differences in those features tapped by the expressed emotion index: (a) cultural interpretations of the nature of the problem (i.e., relatives' interpretations of the problem with regard to its cause, nature, and course, such as laziness caused by illicit drug use if the patient called upon personal reserves of willpower); (b) cultural meanings of kin relations (culturally prescribed definitions of family life and kin ties); (c) identification of cultural rule violations; (d) vocabularies of emotion (culturally salient emotions); (e) relatives' personality traits or dispositions; (f) degrees and kinds of patients' psychopathology; (g) family interaction dynamics; (h) attempts to socially control a deviant relative; (i) availability and quality of social supports; and (j) historical and political economic factors (Jenkins & Karno, 1992, p. 17).

[14]Although affects of warmth and praise are undoubtedly important to many qualitative dimensions of family life, these have yet to be significantly predictive of recovery from major mental disorder. The relationship among criticism, hostility, and emotional overinvolvement has also been found for depressive illness, at even lower thresholds than for schizophrenia (Hooley, Orley, & Teasedale, 1986; Vaughn & Leff, 1976).

Several summary points can be made on the relationship between culture and emotional response to schizophrenic illness: (a) there is considerable cross-cultural variability in social response (e.g., tolerance, support, hostility); (b) variations in emotional response partially account for differential illness outcomes cross culturally; and (c) cultural conceptions of the problem (construed, for example, as witchcraft, *nervios* [nerves], laziness, or schizophrenia) mediate the nature of relatives' emotional response (Jenkins, 1988a, 1988b, 1991a). For example, some conceptions confer a culturally legitimate status that may preclude high levels of personally directed criticism or emotional overinvolvement. Among Mexican-descent families in the United States, the concept of *nervios* serves as a cultural category for schizophrenic illness among the majority of relatives. Because severe cases of *nervios* are not believed to be within a person's control, the afflicted person is deserving of sympathy and tolerance:

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

Thus, emotion can mediate conceptions of illness that may, in turn, be important to the course of schizophrenic disorders.

The most comprehensive anthropological source on depressive disorders is an edited collection by Kleinman and Good (1985), *Culture and Depression: Studies in the Anthropology and Cross-Cultural Psychiatry of Affect and Disorder*. This volume addresses fundamental issues concerning the cultural mediation of affect and affective disorders, depressive cognition and communication, and epidemiological approaches in psychiatric anthropology. This interdisciplinary treatment has contributed to the task of refining the key theoretical issues and empirical study of culture and depression.

When viewed in world perspective, depression is more often symptomatically expressed in somatic than in psychological terms (Kleinman,

1986, 1988a). This observation is highly significant in several regards. First, the fact that depression is often experienced and expressed through an array of bodily complaints (e.g., "my back aches") rather than psychological complaints (e.g., "I feel blue") calls into question the cross-cultural validity of depressed mood or loss of pleasure as universal criterial symptoms of the disorder. Cultural tendencies toward psychologization versus somatization have been more fully reviewed elsewhere (Kirmayer, 1984, 1989; Kleinman, 1986; Kleinman & Kleinman, 1985; Ots, 1990). As summarized by the leading theorist in this area, Kleinman (1986) explained that

> individuals experience serious personal and social problems but interpret and articulate them, and indeed come to experience and respond to them, through the medium of the body. . . . High rates of somatization in depressive disorder, for example, have been found [in numerous cross-cultural studies]. . . . The research literature indicates that depression and most other mental illnesses, especially in non-Western societies and among rural, ethnic, and lower-class groups in the West, are associated preponderantly with physical complaints. (pp. 51–52)

This cross-cultural view of somatic versus psychological symptomatic expression of depression provides the basis for a critical appraisal of dichotomous mind–body approaches to psychological and somatic manifestations of depression. The current *DSM–III–R* defines depression as necessarily a mood disorder with associated somatic symptoms and therefore presupposed a dichotomous mind–body approach to psychological and somatic manifestations of depression. Jenkins et al., (1991) have argued that "insofar as this dichotomous approach distinguishes psyche and soma, it reproduces assumptions of Western thought and culture, [but] must from the outset be suspended in formulating a valid comparative stance. (p. 67)" Thus, an important cross-cultural question is whether the psychiatric construct of depression can validly include both somatic and psychologized forms of depressive suffering or whether these are really distinct kinds of illnesses.

Somatized versus psychologized expressions of dysphoric or depressive affect more generally suggest differences in cultural styles of

sadness, demoralization, suffering, and so forth (Kleinman & Kleinman, 1991). Cultural styles of dysphoria are best understood as elements of indigenous or ethnopsychological models of affect (Lutz, 1988; White & Kirkpatrick, 1985). An understanding of ethnopsychological models of depressive-related affects is essential to cultural studies of depression (Kleinman & Good, 1985). Cultural knowledge of ethnopsychological models is important to specification of the normative bounds of everyday depressive affects, on the one hand, and more serious, extraordinary states that might ethnopsychologically be considered constitutive of a type of depressive illness, on the other.

Several other sets of sociocultural factors must also be taken into account in cross-cultural studies of depression. Jenkins et al., (1991) have provided a critical review of the varying roles of diverse sociocultural factors in the production of and recovery from depressive illness. Principal among these are socially inculcated gender differences in susceptibility to depression, documented in an overwhelming number of Western and non-Western studies. Lower socioeconomic status has commonly been found to be associated with symptoms of depression, and a growing body of research suggests that adverse life events and conditions may partially underlie the broad-based conclusions regarding social class and vulnerability to depression (Brown & Harris, 1978). Migrant status (immigrant or refugee) and social change have also commonly been found to be associated with major depressive illness (Farias, 1991; Jenkins, 1991b; Kinzie, Frederickson, Rath, Fleck, & Karls, 1984; Mollica et al., 1987; Westermeyer, 1988, 1989). Also relevant are cultural variations in family factors such as composition and organization, socialization practices, family histories of depression, marital discord, and expressed emotion (reviewed above for schizophrenia; see also Hooley et al., 1986; Vaughn & Leff, 1976). Review of these foregoing factors leads to the conclusion that "culture is of profound importance to the experience of depression, the construction of meaning and social response to depressive illness within families and communities, the course and outcome of the disorder, and thus to the very constitution of depressive illness" (Jenkins et al., 1991, p. 68).

Conclusion

I have summarized current anthropological approaches to culture, emotion, and psychopathology as falling within five interrelated domains of study. These include psychological anthropological studies of emotion and self, medical anthropological studies of dysphoric affects and affective disorders, phenomenological accounts of the body as a generative source of culture, sociopolitical analyses of emotion, and experiential accounts of dysphoria and suffering. All of these areas are critical fields of study from which arise key questions concerning the relations among culture, emotion, and psychopathology. There is a short supply of emotion studies based on intersubjective dimensions of culture and experience as a complement to studies of emotion based on lexicon, discourse, ethnopsychological category, and expression. In addition, the anthropological and psychological literature has typically failed to integrate experiential, sociocultural, and political dimensions of sentiment. A methodological limitation of emotion studies has been the disproportionate reliance on verbal (and nonverbal) communication.

Cultural approaches to the study of emotion and psychopathology have proliferated in recent years. Nevertheless, we have yet to see the full development of what could be considered affective anthropology or affective psychology. Along with Western traditional views of the superiority of mind over body, there is currently a strong bias toward cognitive science. Although cognitive anthropology has made a powerful scientific contribution to the anthropological endeavor, relatively little psychological and anthropological attention has been directed toward the full range of emotion phenomena and can productively be addressed in future studies.

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