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 color 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 color fails to distinguish between anger and fear and therefore must be considered to be subemotional. Instead, one can easily conceive of el color 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 color and had the emotion of fear than it is to say that el color 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, 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): Badan (Nigeria), Cali (Colombia), Agra (India), Ahvaz (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

*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). 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 (Blueher, 1980).

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. 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.

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, non-disabling courses and outcomes than was the case in Aarhus, London, Moscow, Prague, and Washington" (Sartorius, Kaplansky, & 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 & Letf, 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 through criticism) and emotional overinvolvement (expressed in unusually self-sacrificing, overprotective, or intrusive behaviors on the part of close relatives). \(^{11}\)

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 (1981a) and Jenkins and Karno (1982). As Jenkins and Karno (1982) 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 support; and (j) historical and political economic factors (Jenkins & Karno, 1992, p. 17).

\(^{11}\) Although affect 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, O'lay, & Trancik, 1986; Vaughn & Leff, 1975).

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 (constructed, for example, as witchcraft, nervous [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 nervous serves as a cultural category for schizophrenic illness among the majority of relatives. Because severe cases of nervous 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, nervous, 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; Oes, 1980). 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; Westernmeyer, 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 & Lefth, 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.

References


