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Contemporary Theory and Method

Revised Edition

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Contents

world and its culture-bound definitions of reality. To admit the "as-ifness" of our ethnoepistemology is to court a Cartesian anxiety: the fear that in the absence of a sure, objective foundation for knowledge, we would fall into the void, into the chaos of absolute relativism and subjectivity (see Geertz 1973a: 28–30).

We have tried to show the interaction among the mind-body and the individual, social, and body politic in the production and expression of health and illness. Sickness is not just an isolated event or an unfortunate brush with nature. It is a form of communication—the language of the organs—through which nature, society, and culture speak simultaneously. The individual body should be seen as the most immediate, the proximate terrain where social truths and social contradictions are played out, as well as a locus of personal and social resistance, creativity, and struggle.

NOTES

1. This chapter is not intended to be a review of the field of medical anthropology. We refer interested readers to a few excellent reviews of this type: Landy (1983a); Worsley (1982); Young (1982). With particular regard to the ideas expressed in this chapter, however, see also Comaroff (1985), Csordas (1994), Devisch (1985), Estroff (1981), Good (1994), Good and Good (1981), Hahn (1985), Helman (1985), Kleinman (1986, 1988b); Laderman (1983, 1984), Lindenbaum and Lock (1993), Low (1985a), Morgan (1993b), Nichter (1981), Obeyesekere (1981), and Taussig (1980a, 1984).

2. Mary Douglas refers to "The Two Bodies," the physical and social bodies, in *Natural Symbols* (1970). More recently John O'Neil has written *Five Bodies: The Human Shape of Modern Society* (1985), in which he discusses the physical body, the communicative body, the world's body, the social body, the body politic, consumer bodies, and medical bodies. We are indebted to both Douglas and O'Neil and also to Bryan Turner's *The Body and Society: Explorations in Social Theory* (1984) for helping us to define and delimit the tripartite domain we have mapped out here.

3. We do not wish to suggest that Hippocrates' understanding of the body was analogous to that of Descartes or of modern biomedical practitioners. Hippocrates' approach to medicine and healing can be described only as organic and holistic. Nonetheless, Hippocrates was, as the quotation from his work demonstrates, especially concerned to introduce elements of rational science (observation, palpation, diagnosis, and prognosis) into clinical practice and to discredit all the "irrational" and magical practices of traditional folk healers.

4

Culture, Emotion, and Psychiatric Disorder

Janis H. Jenkins

The study of the interrelations among culture, emotion, and psychiatric disorder is central to the fields of medical and psychological anthropology.[1] This has become evident with the convergence between the recent wave of psychocultural studies of emotion (Abu-Lughod 1986, 1993; Gaines and Farmer 1986; Good and Good 1988; Jenkins 1991b; Hollan 1988; Hollan and Wellenkamp 1994; Kleinman and Good 1985; Lutz 1985b, 1988, 1990; Lutz and White 1986; Kitayama and Markus 1994; Matthews 1992; Myers 1986; Ochs and Schieffelin 1989; Rosaldo 1980b; Roseman 1991; Scheper-Hughes and Lock 1987; Schieffelin 1976; Shweder and LeVine 1974; Wellenkamp 1988; Wikan 1990) and a long-standing interest in psychological and medical anthropology in studies of ethnopsychiatry (Caudill 1958b; Devereux 1969; Edgerton 1966, 1969, 1971a, 1971b; Hughes this volume; Hallowell 1938, 1955; Kennedy 1974; Sapir 1961; Scheper-Hughes 1979; Sullivan 1953; Wallace 1961). Taken together, these studies argue that since virtually every aspect of illness experience is mediated by personal and cultural sentiment, the study of emotion is necessarily of relevance to medical anthropology.

The domain of emotion has recently been elaborated as a cultural problem in the light of anthropological challenges to the presumption of a psychobiological universality of emotional life (Gaines 1992; Kitayama and Markus 1994; Rosaldo 1984; Kleinman and Good 1985; Lutz 1988; Schwartz, White, and Lutz 1992; Shweder and LeVine 1984; Stigler, Shweder, and Herdt 1990). Revitalization of the study of psychopathology in culturally interpreted terms has occurred in the wake of the "new cross-cultural psychiatry" (Hopper 1991; Kleinman 1977, 1980, 1988a; Littlewood 1990) and "meaning-centered medical anthropology" (Good and Good 1982; Good 1994; Good 1995). This chapter

explores these developments in the anthropological study of emotion and mental disorder by drawing out conceptual issues common to each.

While implicit claims about emotion abound in classic ethnographies (Bateson 1958; Benedict 1934; Mead 1935; Hallowell 1955), explicit and sustained theorizing on emotion has emerged only recently. Where studies of culture and personality once held sway, studies of culture and emotion are now numerous. In psychological anthropology, previously suitable topics would likely include, for example, motivation, cognition, perception, dreams, and values but not emotion (Bock 1980; Barnouw 1973; LeVine 1974; Spindler 1978).[2] Where subdisciplines of "cognitive anthropology" or "cognitive psychology" appeared, similar attention was not granted to "affective anthropology" or "affective psychology."

The relative valuation of cognition at the expense of emotion is embedded in the mind-body dualisms that structure scholarly thinking on the issue. Feminist theories of gender, emotion, and social relations (Lutz 1988, 1990; Lutz and Abu-Lughod 1990; Rosaldo 1984; Miller 1993) shed light on this dualism by revealing symbolic associations of emotion with the irrational, uncontrollable, dangerous, natural, and female (Lutz 1988).[3] Catherine Lutz's (1988) analysis of these complex cultural logics reveals contradictions among the cherished presuppositions that constitute the domain of emotion in scientific and popular discourse. For example, while emotional expression is generally devalued in favor of a rational, controlled demeanor, failure to demonstrate "basic" human emotions renders one "estranged" from an innate human capacity for feeling (Lutz 1986). The particular associations of emotion, the body, and women has also been examined by Emily Martin (1987).

The historic anthropological ambivalence and neglect of the cultural category of "emotion" can therefore be understood in relation to how some scholarly topics are deemed worthy or otherwise (Ortner 1974; Lutz 1990). Emotion has emerged as an explicit problem in cultural anthropology only recently because the passions have been considered secondary cultural artifacts relative to more "cognitively" conceived objects such as beliefs, propositions, and values. With the expansion of the conceptual horizons of medical and psychological anthropology, however, emotion is now regarded as properly situated within a cultural repertoire. This problem will be addressed further below in relation to the question of how the construct of culture suggests (or constrains) questions about emotion.

Current studies by psychological anthropologists cover a range of emotion topics that include child-rearing practices and the socialization of emotion (Clancy 1986; Ochs and Schieffelin 1986; Weisner 1983; LeVine 1990); the cultural constitution of the self (Csordas 1994; Hallowell 1955; Marsella, DeVos, and Hsu 1985; Shweder and Bourne 1990; White and Kirkpatrick 1985); cross-cultural variations in the experience and expression of emotion (Briggs 1970; Edgerton 1971b; Shweder and LeVine 1984; Levy 1973; Myers 1979; Schieffelin 1983; Wikan 1990; Roseman 1991); cognitive approaches to emotion

(D'Andrade 1987; Holland 1992; Lakoff and Kovecses 1987; Lutz 1982; White 1992); linguistic studies of emotion (Beeman 1985; Ochs and Schieffelin 1986; Lutz 1988; Matthews 1992; Solomon 1984; White and Kirkpatrick 1985); violence, sexual abuse, and child development (Korbin 1987; Scheper-Hughes 1992); and theoretical examination of Western scientific discourse on emotion (Lutz 1988; Lutz and Abu-Lughod 1990; Rosaldo 1984).

In contrast to the case of emotion, mental disorder has long been the subject of study in both medical and psychological anthropology. This interest stems in large measure from the collaboration of Edward Sapir (1961) and Harry Stack Sullivan (1962) for whom the study of mental disorder was considered essential to an understanding of fundamental (and divergent) human processes. Sullivan and Sapir insisted that a person with a psychiatric disorder must be studied in interpersonal contexts, with particular attention paid to the emotional atmosphere (Jenkins 1991a). Although their collaborative program for the study of culture and mental disorder never fully reached its potential in psychological anthropology (Darnell 1990; Perry 1982; Kennedy 1974), their works still stand as an important foundation for current studies in this area. To draw a parallel between emotion and psychopathology, the early conceptualization of mental disorder as socially transacted has as its counterpart the contemporary formulation of affect as interactive construction (Jenkins 1991).

Reconsideration of relations among culture, emotion, and psychopathology therefore requires examination of enduring and previously unexplored questions: What is particularly cultural about emotion and psychopathology? How are emotion and mental disorder to be conceived: as intrapsychic mental events or intersubjective social processes? As biologically natural events or sociopolitically produced reactions? Can cognitively comprised "emotion" be differentiated from bodily "feeling"? How is "illness" to be distinguished from "pathology"? In what sense might an emotion be termed "abnormal"? How are emotions to be probed in relation to "mental" disorders such as schizophrenia or depression?

CULTURE, ETHNOPSYCHOLOGY, AND ETHNOBIOLOGY

Before proceeding further, it will be helpful to provide a working definition of culture as used in this chapter. This is so not merely because I wish to introduce my particular use of the term *culture* as a basis for my discussion of emotion and psychopathology but also because the concept of culture has become so controversial that some may prefer to abandon it altogether. Identification of problems with the notion of culture has resulted in a significant movement to substitute the term *discourse.* Some find that the concept of culture presumes an uneasy coherence, a static and ahistorical notion that excludes agency (Abu-Lughod and Lutz 1990; White and Lutz 1992). The term *discourse,* however, has a variety of quite specific meanings in fields ranging from literary criticism to conversational analysis, and the new role for discourse sacrifices

this specificity for the sake of a linguistic and textual slant on the domain subsumed under the term *culture.* It will do just as well to be clear about what counts as culture, taking advantage of the sustained revision of culture theory over the past several decades.

I take culture to be a context of more or less known symbols and meanings that persons dynamically create and recreate for themselves in the process of social interaction. Culture is thus the orientation of a people's way of feeling, thinking, and being in the world—their unself-conscious medium of experience, interpretation, and action. As a context, culture is that through which all human experience and action—including emotions—must be interpreted. This view of culture attempts to take into consideration the quality of culture as something emergent, contested, and temporal (White and Lutz 1992), thereby allowing theoretical breathing space for individual and gender variability and avoiding notions of culture as static, homogeneous, and necessarily shared or even coherent. I would argue that such a conceptualization of culture is crucial for comparative studies of psychopathology (Jenkins and Karno 1992:10). It encompasses the indeterminacy of experience and subjectivity that are submerged both by restricting the debate to discourse and by reducing it to a generalized baseline from which individuals and groups may, and often do, deviate.[4]

An essential step toward culturally informed models of emotion is the investigation of indigenous ethnopsychologies. Ethnopsychological issues include the constitution of the self; indigenous categories and vocabularies of emotion; the predominance of particular emotions within societies; the interrelation of various emotions; identification of those situations in which emotions are said to occur; and ethnophysiological accounts of bodily experience of emotions. These elements of ethnopsychology will mediate both the experience and expression of emotion, presuming the existence of an actively functioning (or dysfunctioning) psyche in transaction with the social world.

Whether labeled as ethnopsychology or as cultural psychology, compared to psychologists' definitions of emotion within a framework of stimulus properties, physiological manifestations, and behavioral responses (Fridjda 1987), anthropological frameworks appear considerably more broad ranging (Shweder 1990). Consider Michelle Rosaldo's anthropological definition of emotion: "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" (see Rosaldo in Levy 1983: 128). In general, the anthropological conception of emotion as inherently and explicitly cultural (Lutz 1982, 1988; Rosaldo 1980b, 1984) is designed to encompass a broader social field than psychological definitions of emotion as individual response to stimulus events. What is cultural about emotion is that emotion necessarily involves an interpretation, a judgment, or an evaluation (Soloman 1984; Rosaldo 1984). However, as Lila Abu-Lughod (1990:26) has recently cautioned, there may be a problem with privileging cultural-cognitivist accounts of emotion "such as understanding, making sense of, judging, and interpreting, [since] these theorists may be inadvertently replicating that bias toward the mental, idealist, or cognitive that Lutz (1986) points out is such a central cultural value for us."

On the other hand, anthropologists have also disputed essentialist claims of basic, universally shared emotions based on innate, uniform processes where "brute, precultural fact" is bedrock (Geertz 1973a).[5] The presumption of biological regularity and similarity of human emotional life has been challenged by several ethnographic accounts (Lutz 1988; Kleinman 1986; Rosaldo 1980b). Robert Plutchik (1980:78) exemplifies the natural science approach to the psychological study of emotion in his search for a set of basic emotions that are the equivalent to Mendeleyev's periodic table in physics or Linnaeus's system of classifications in biology. In contrast, anthropological studies are likely to highlight the cultural specificity and situatedness of emotion. The conceptualization of emotion as situationally constituted in social settings has been firmly established in the theoretic formulations of Lutz (1988, 1990). Her analyses of the emotional repertoire of the Ifaluk serve as a powerful retort to the notion of basic, universally recognizable emotions. It is also within this Ifalukian ethnographic light that emotion is found not to reside within hearts or minds of individuals but in the mutually transacted terrain of social and political space.

James Russell (1991:445) has taken issue with Lutz's assertion that Ifaluk emotion terms (*song* [or justifiable anger], for example) do not refer to a person's internal state but rather to something external. He cites Lutz's finding that Ifaluk terms sometimes define emotions as "about our insides" and raises "the conceptual issue of how a word in any language that does not refer to an internal state could be said to be an emotion word. If *song* were a member of a class of words that, like *marriage* or *kinship,* referred to a relationship, then the reason for calling *song* an emotion word is unclear" (Russell 1991:445). Russell interprets the problem as a conflation of sense and reference and suggests that the proper interpretation is that *song* refers to an internal state created when certain external circumstances occur. There are two problems with this critique. First is a conceptual difficulty with the equation of marriage, kinship, and emotion in that the last is inherently evaluative and interpretive (as formulated by Lutz), whereas the former are things that emotions are about. The assertion that emotions are located in social space (rather than individual, internal space) does not "externalize" emotion in such a way to render it conceptually similar to marriage or kinship. Second, there may be a difficulty with just what kind of self is premised here. Should the self be ethnopsychologically conceived as private, bounded, and separate, the notion of "internal" states may make cultural sense. However, if the self is more social-relationally conceived, the "internal" and "external" dichotomy may prove an unsatisfactory point of comparison.

Yet Russell's concern with the theoretic representation of the ethnographic fact that Ifaluk emotion words are sometimes defined as "about our insides" may suggest a genuine dilemma: the need for the representation of subjective experience in anthropological constructs for emotion. This problem is significant

since emotion necessarily involves subjectivity (and intersubjectivity) in presupposing some object about which the subject is feeling (Shweder 1985; Fridja 1987). The socially constructed object might be not only a human person (or group) but also a deity, demon, animal, or landscape. The role of subjectivity for emotion cannot be confined to one ethnopsychological version of emotion but can instead be productively employed in comprehensive studies of emotion cross-culturally. At present the problem of emotion as subjective experience is still mostly neglected by anthropologists, a difficult area not much advanced beyond the pioneering work by A. Irving Hallowell (1938, 1955). The difficulty, however, should not dissuade us from investigation of what must be regarded as a crucial dimension of emotion realms.

Psychological and cognitive researchers have tended to distinguish between emotion, on the one hand, and feeling, on the other (Levy 1984). By *emotion*, psychologists have tended to mean cognized, behavioral response, whereas by *feeling* they have tended to mean physiologically based sensation. In contrast to the mental nature of emotion, the contemporary distinction dualistically construes feelings as physical. The consequences of this scientific dichotomy are that (1) feelings are understood as biological while emotions are constructed as cultural and (2) feelings as biological are further construed as universal and immutable, whereas emotions alone may reasonably be thought of as cross-culturally variable. Because feelings are immutable, they are no longer problematized. However, the very notion that emotion is cultural, cognitive, and interpretive while feeling is homogeneous, biological, and universal is inherently problematic. An enduring contribution of William James (1884) and more recently of Michelle Rosaldo (1984) is the observation that a disembodied emotion is a nonentity. Emotion and feeling cannot be separated; emotion must involve feeling.

MEDICAL ANTHROPOLOGY, EMOTION, AND SOCIOPOLITICAL ANALYSES

In medical and psychiatric anthropology, researchers have examined cultural dimensions of dysphoria generally and affective and psychotic disorders in particular. An abbreviated sampling from domains of inquiry in this area would include cultural meanings and indigenous conceptions of distress and illness (Gaines and Farmer 1986; Good and Good 1982; Good 1994; Jenkins 1988; Kirmayer 1984; Low 1985a; Lutz 1985b; Tousignant 1984); "culture-bound syndromes" (Carr and Vitaliano 1985; Simons and Hughes 1985); comparative treatments of the cultural validity of psychiatric syndromes cataloged in the American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM) (Gaines 1992; Good, Good, and Moradi 1985; Good 1992; Hopper 1991, 1992; Kleinman 1980, 1986, 1988a; Manson, Shore, and Bloom 1985); emotional climates and the course of mental disorder (Corin 1990; Karno 1987; Jenkins 1991a; Jenkins and Karno 1992); epidemiological studies of affective and anxiety disorders (Guarnaccia, Good, and Kleinman 1990; Beiser 1985; Manson, Shore, and Bloom 1985); phenomenological accounts of embodiment and illness experience (Csordas 1990b, 1993b; Frank 1986; Good 1993; Kleinman 1988b; Ots 1990; Scarry 1985), and the medicalization of social problems and human suffering in Western scientific discourse (Fabrega 1989; Kleinman 1988a; Kleinman and Good 1985; Scheper-Hughes and Lock 1987).

Another area that has very recently emerged concerns sociopolitical analyses of emotion (Feldman 1991; Jenkins 1991a, Jenkins and Valiente 1994; Nordstrom and Martin 1992; Scheper-Hughes 1992). Mary-Jo DelVecchio Good and Byron Good (1988) have introduced the idea of the "state construction of affect," or the production of sentiments and actions by the nation-state. They argue for the importance of the "role of the state and other political, religious, and economic institutions in legitimizing, organizing, and promoting particular discourses on emotions" (Good and Good 1988:4). Lutz and Abu-Lughod's (1990) analysis of the interplay of emotion talk and the politics of everyday social life is also significant here. They redirect scholarly attention away from largely privatized and culturalized representations of emotion to examination of emotion discourse in the contexts of sociability and power relations. Another important formulation in this area comes from Kleinman's (1986) studies of affective disorder. His analysis of case studies from China in the period following the upheaval of the Cultural Revolution provides a convincing argument for the social and political production of affective disorders. In a case study of El Salvador, Jenkins (1991a:139) seeks to extend current theorizing on emotion "by examining the nexus among the role of the state in constructing a 'political ethos,' the personal emotions of those who dwell in that ethos, and the mental health consequences for refugees." Other recent literature on the mental health sequelae of sociopolitical upheaval includes treatment of Latin America (Farias 1991; Suarez-Orozco 1989), Southeast Asia (Mollica, Wyshak, and Lavelle 1987; Westermeyer 1988), and South Africa (Swartz 1991).

Emphasis on sociopolitical aspects of affectivity expands the parameters of emotion theory beyond the biological, psychological, and cultural. Closely related to much of this current thinking is feminist theory, which has long been analytically concerned with power relations and inequities (rather than differences) in global context (Rosaldo and Lamphere 1974; Miller 1993). Feminist analyses also question the limits of cultural relativism through grounded locational perspectives on human experience and the human condition (Haraway 1991). The argument here is that the emerging agenda for studies of emotional processes and experience must take political dimensions into account in any of an array of intentional worlds large and small.

"NORMAL" AND "PATHOLOGICAL" EMOTION: DISCONTINUOUS CATEGORIES OR POLES ON A CONTINUUM?

In what sense can we draw a distinction between "normal" and "pathological" emotion? If normal emotions are those commonly shared within cultural

settings, are abnormal emotions those outside the range of normal human experience within a particular community? Or within the range of normal experience but inappropriate to a particular setting or event? What criteria would render an emotion or emotional state "abnormal"? Here we encounter the enduring question of whether the normal and pathological are discontinuous categories or poles of a continuum. In the study of emotion and psychopathology we have yet to resolve the problem of what Georges Canguilhem (1989) defined as the ontological versus positivist conceptions of disease. Is there, as the ontological view would have it, a distinct qualitative difference between depression as a normal emotion and depression as a pathological state? If so, is this based on some pathogenic alteration or on some "inborn error" of biochemistry with a genetic origin? Or, as the positivist view would hold, is there only one depression, the intensity of which can vary quantitatively from total absence to a degree that becomes so great as to be pathological? In this view, abnormality is defined as "more" of what otherwise might be considered within the bounds of normal human experience. Canguilhem (1989:45) quotes Nietzsche as follows: "It is the value of all morbid states that they show us under a magnifying glass certain states that are normal—but not easily visible when normal."

In a more contemporary vein, Sullivan argued that there is no definitive threshold distinguishing healthy from ill individuals. The inability to recall a name that is "right on the tip of one's tongue" is a mental disorder in the same sense as is schizophrenia, albeit much less severe. Sullivan maintained that schizophrenic illness could productively be considered as a paradigmatic case for the analysis of fundamental human processes (Sullivan 1962).

In theory, contemporary psychiatry and medicine have for some time been dominated by the quantitative perspective, with its corollary that since they are essentially the same, studies of the pathological can help us understand the normal, and vice versa. However, in actual diagnostic practice, a curious mixture of quantitative and qualitative criteria is characteristic in psychiatry today. The qualitative criteria revolve around the specific symptoms that comprise the symptom cluster or syndrome for a given diagnostic category. Yet the DSM-IV (American Psychiatric Association 1987) is unhesitatingly organized in quantitative terms according to three kinds of criteria: (1) intensity or severity of specific experiences/symptoms (generally exceeds normal range); (2) duration of the experiences (generally longer than usual); and (3) occurrence of the symptom along with one or more other affective, cognitive, and behavioral phenomena that form a particular configuration or symptom profile. It should be obvious that the particular psychiatric symptoms selected for attention as well as the cutoff points for cooccurring symptoms, their duration and severity, are somewhat arbitrary. Failure to meet criteria of enough symptoms of sufficient duration is a failure to meet the parameters of particularly defined syndromes. Therefore, patients who meet some but not all of the designated classificatory category are considered "subclinical." Most persons have at least some experience of the myriad of diverse symptoms cataloged in the DSM. Whether this observation

provokes anxiety or amusement, it is evidence of the continuous nature of such definitions of psychopathology. Much normal range experience is cataloged in those 567 pages.

According to psychiatric diagnostic procedure, emotions are unusual or abnormal not because they are unrecognizable features of human experience but because they appear more severe and prolonged, and they often cooccur with an array of other behavioral or cognitive disturbances that (as a syndrome) are outside the range of culturally prescribed orientations to the world. On the other hand, when we move from diagnosis to the etiology and ontology of psychiatric disorder, the dominant paradigm argues that there is a qualitative gulf between normal and pathological. Pathology is a result of a genetically based "inborn error of metabolism," a qualitative anomaly, or even a kind of lesion.

There are other more specific ways in which the continuity or discontinuity between normal and pathological is incorporated in our thinking. Take, for example, the delusional fear that a university president wants a given male faculty member dismissed from his position. Quantitatively, such a person might find this fear becoming increasingly intense or being just a passing notion that is extinguished when it is shrugged off as silly. On the other hand, qualitatively there would be a definite discontinuity between a mistaken idea and a fixed delusion about a university president, for given the proper evidence, the former can be changed or corrected and the latter cannot. Again, although delusions can become quantitatively more or less intense and rigid, true delusions have the qualitative feature of exfoliating into a system, adding more and different and even absurd elements. The delusion that the president of the university wants one dismissed from his position can become the idea that the president, provost, dean, and department chair are in a conspiracy and can come to include the fact that they especially want his parking space taken away. Again, depending on the way an emotion is formulated, it may presuppose a quantitative or qualitative notion of normal versus pathological. For example, one might conceive a qualitative continuum between happiness and sadness, with clinical mania and depression at the pathological extremes of the continuum. On the other hand, when it comes to the symptomatic "flat affect" of schizophrenia, one thinks of a quantitative continuum between flatness and expressiveness. Could one formulate a qualitative distinction between normal flat affect and pathological flat affect? The differences between quantitative and qualitative, continuous and discontinuous, easily become quite tangled. As Canguilhem observed, "the continuity between one state and another can certainly be compatible with the heterogeneity of these states. The continuity of the middle stages does not rule out the diversity of the extremes" (1989:56).

EMOTION AND PSYCHIATRIC DISORDER

Systematic study of emotion and psychopathology requires examination of the following questions: How are the phenomenological worlds of persons with

major mental disorder culturally elaborated? What consequences ensue for cross-culturally valid diagnoses if emotions are considered as cultural objects? Are there cross-cultural variations in emotions expressed by kin about a relative with a major mental disorder? Does emotional response on the part of kin mediate the course and outcome of a psychiatric disorder? This section explores these issues in the context of the major disorders of schizophrenia and depression. A cogent rationale for the productive use of specific DSM diagnostic categories (as opposed to generalized distress) in anthropological studies of culture and psychopathology has been already provided by Byron Good (1992). Good agrees that although they are plainly grounded in Western cultural assumptions, they are systematic enough to be used as the basis for cross-cultural research and to be subject to critique as the result of that research.

With respect to the cross-cultural study of the phenomenology of psychosis, little is known about the processes whereby selves and emotional atmospheres constitute worlds of experience for persons living with schizophrenia. At issue is the fundamental question of how psychiatric illness is emotionally experienced. Is schizophrenic psychosis, for example, nearly always and everywhere devalued as a terrifying experience? While many feel this is likely to be the case, we cannot know with certainty since the cross-cultural ethnographic and clinical record is notably thin with respect to phenomenological accounts of mental disorder (Kennedy 1974; Kleinman 1988a, 1988b). Jenkins (1991a) has summarized cross-cultural studies of "emotional atmospheres" to document not only the variation in everyday experience but also the importance of that emotional experience in mediating the course and outcome of major mental disorder.

For theoretical orientation to future phenomenological studies of psychosis, it may be useful to reconsider ideas long ago introduced by Sullivan (1953). Recall that for Sullivan, mental disorder is properly conceived not as a discrete disease entity but as an interactive process. This has major implications if used as a cross-cultural starting point for investigation since it would appear to require that mental disorder be examined within the arena of everyday social life rather than in the brain scan or clinic. For Sullivan, psychiatry "is not an impossible study of an individual suffering mental disorder; it is a study of disordered interpersonal relations nucleating more or less clearly in a particular person" (p. 258). Not sick individuals but "complex, peculiarly characterized situations" are then the target of cross-cultural research and therapy. Sullivan's theory is premised on a notion of the "self-system" as a constellation of interpersonal mechanisms in the service of emotional protection against a noxious emotional milieu (Sullivan 1953). Here the self is not a discrete and fixed entity but instead a constellation of interpersonal processes developed during childhood and adolescence. This view of self as intersubjective creation leaves behind the more usual intrapsychic and individuated configuration in psychiatric science. Thus these early theoretical formulations by Sullivan provide a bridge between the subjective experience of the afflicted self and the world of everyday social interaction.

Emotion and Schizophrenic Disorders

In this section, emotion issues are examined in relation to the content and form of diagnostic symptom criteria for schizophrenia and illness processes relevant to the experience, manifestation, and the course and outcome of schizophrenia. Exploration of the emotional dimensions of schizophrenia serves to underscore the point that emotion should be considered no less central to so-considered thought disorders (i.e., the schizophrenias) than to mood disorders (i.e., affective disorders).

The cross-cultural evidence appears to support the notion of important variation in both the content (e.g., delusions about witches rather than about popular performing artists) and form (e.g., visual, auditory, or tactile hallucinations) of schizophrenic symptomatology. An early report from HBM. Murphy et al. (1963) lists four schizophrenic symptoms as common cross-culturally: (1) social and emotional withdrawal, (2) auditory hallucinations, (3) delusions, and (4) flatness of affect. In addition, the early transcultural psychiatric reports provide documentation of significant differences in the manifestation of symptomatology. For example, "falling toward the quiet, nonaggressive end of the continuum appear to be patients from India, the Hutterites, and the Irish. Toward the noisy, aggressive side would probably come the Africans, Americans, and Japanese" (Kennedy 1974:1148–49). Cross-cultural variation in the subtypes of schizophrenia, such as paranoia, hebrephenia, and catatonia, has also been widely noted (WHO 1979b). The pathoplasticity of symptom formation and expression has been interpreted by Kennedy (1974:1149) as providing evidence not only of the cultural shaping of the disorder but also of the likelihood that "schizophrenia" does not denote a single disease process. It is probable that as a research and clinical construct, schizophrenia is better conceived as a plurality of disorders rather than a unitary diagnostic category.

Anthropological analysis of the specific symptoms from the American Psychiatric Association's most recent edition of the DSM (DSM IV) for the category of schizophrenia makes it evident that all prodromal, actively psychotic, and residual symptoms must be evaluated with reference to the patient's cultural context. Failure to do so can result in misdiagnosis. Broadly conceived, symptom criteria include the patient's sense of self, behavioral repertoire, beliefs, cognitive style, and affects. Narrowly conceived, and for the purposes of differential diagnosis, the DSM IV symptom criteria are (1) delusions, (2) hallucinations, (3) disorganized speech, (4) grossly disorganized or catatonic behavior, and (5) negative symptoms (i.e., affective flattening, alogia, or avolition). While delusions, hallucinations, disorganized speech, or behavior might all arguably be affective in nature (i.e., how can these have no culturally specific affective coloration?), culture in relation to the so-called negative[6] symptoms is of particular interest to this analysis. This is particularly so in the case of flat affect, long thought to be pathognomonic for schizophrenia.

"Flat" or "blunted" affect is defined as a "disturbance of affect manifest

by dullness of feeling tone'' (Freedman, Kaplan, and Sadock 1976:1280). To examine this symptom cross-culturally, I turn to cross-cultural data on schizophrenic symptomatology as collected by the World Health Organization's (WHO) International Pilot Study of Schizophrenia (IPSS). The IPSS conducted a longitudinal study of schizophrenic symptomatology and course of illness. Psychiatric assessments were completed for 1,202 patients in nine countries (United Kingdom, Soviet Union, United States, Czechoslovakia, Denmark, China, Colombia, Nigeria, and India). Two-year follow-up data (WHO 1979b) across all sites provide a striking range in the presence of flat affect: from 8 (Ibadan, Nigeria) to 50 percent (Moscow, Russia) of patients were so rated.[7] A slight tendency for flat affect to be more common among patients from the more industrialized countries was noted. In addition, flat affect was recorded as the second most common symptom.[8] While these longitudinal data suggest important cross-cultural differences in the presence of flat affect, methodological questions remain as to precisely how flat affect was assessed. The lack of systematic discussion by IPSS investigators on this point is troubling. The cross-cultural variation in emotional experience and expression generally and in schizophrenic symptomatology specifically render the culturally valid assessment of flat affect a complicated undertaking.

The other two DSM IV negative symptoms of schizophrenia—alogia[9] and avolition—have been subjected to even less systematic cross-cultural examination. Alogia (speechlessness that may be resultant from psychotic confusion) is of particular cultural and sociolinguistic concern insofar as the language and ethnicity of the individual conducting the psychiatric assessment may differ from those of the patient. Certainly the symptom of avolition can be expected to vary substantially in relation to culturally constituted capacities such as self, agency, motivation, and the meaning of purposeful action (Karno and Jenkins 1995).

A second area of research concerns emotion and schizophrenic illness processes. This processual approach to affective components of schizophrenic illness can be considered in relation to the experience of emotion, on the one hand, and the expression of emotion, on the other. With respect to experience, questions arise in regard to everyday phenomenological constitution of affect in relation to schizophrenic illness. While a full range of affects may be experienced by the patient, fear and terror have often been a large part of schizophrenic experience (Glass 1989). The question of the illness experience of families has been more systematically investigated in relation to emotional expression about the patient and his or her illness. The suggestion that kin and community emotional response to schizophrenic illness may vary cross-culturally is certainly present in early reports from transcultural psychiatry. Nancy Waxler (1974, 1977), for instance, has maintained a greater tolerance for schizophrenic illness in non-Western settings. Following a systematic analysis of the WHO (1979a) data on recovery from schizophrenia, Edgerton (1980) points out that the findings of better prognosis in non-Western settings may not reflect especially salutary conditions in those settings but instead noxious features within more

industrialized nations. Cohen (1992) also disputes Waxler's claim and raises questions about her findings. (See Hopper 1992 and Warner 1992 for critical commentaries on Cohen's article.) (For additional reviews and critiques of the WHO studies, Hopper (1991) and Edgerton and Cohen (1994) identify specific methodological shortcomings.)

Three decades of research on ''expressed emotion'' serve as confirmation that emotional response to schizophrenic illness not only varies substantially cross-culturally but also mediates course and outcome (Brown, Birley, and Wing 1972; Vaughn and Leff 1976a; Vaughn et al. 1984; Karno et al. 1987; Jenkins and Karno 1992). In particular, the ''expressed emotion'' factors of criticism, hostility, and emotional overinvolvement[10] show considerable variability (Brown, Birley, and Wing 1972; Vaughn and Leff 1976a; Karno et al. 1987; Vaughn et al. 1984). Lower levels of criticism and emotional overinvolvment have been found observed among Indian, British, and Mexican-descent families than among Euro-American families (Jenkins and Karno 1992). Moreover, persons suffering from a schizophrenic illness who reside with critical, hostile, or emotionally overinvolved relatives are far more likely to suffer a relapse or exacerbation of symptoms compared to their counterparts who reside in households noteworthy by virtue of the relative absence of such factors.

To account for the link between ''expressed emotion'' and schizophrenic outcome, the hypothesis of a heightened vulnerability to negatively constituted family atmospheres has been put forward (Vaughn 1989). This formulation is merely general, however, and much remains to be examined with respect to the specific mechanisms of how such processes unfold. In addition, the specifically cultural basis of the ''expressed emotion'' construct has yet to be fully appreciated by psychiatric researchers (Jenkins 1991a; Jenkins and Karno 1992). Certainly the emotional response to schizophrenic illness must be understood as mediated by cultural conceptions of the nature of the problem (for example, ''witchcraft,'' ''*nervios,*'' ''laziness,'' or ''schizophrenia''). Such analyses draw our attention to the inherently affective nature of conceptions of mental disorder (Jenkins 1988; Fabrega 1982). To the extent that cultural conceptions of illness may partially determine which affects surround the illness and, conversely, which emotional stances may suggest the saliency of particular conceptions of the problem, we must be concerned with how such reciprocally constructed responses mediate the course of disorder.

The IPSS also provides evidence of a cross-culturally variable course of schizophrenia. The IPSS concluded 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, Jablensky, and Shapiro 1978:106). While the IPSS investigators believed that this variation was probably accounted for by social and cultural factors, they could not submit their hypothesis to examination since sociocultural data were not systematically collected. Insights into the possible cultural sources

of variation are offered in two especially careful and critical reanalyses of these data of the IPSS and "expressed emotion" data recently published by Hopper (1991, 1992). Additional evidence for the important role of the emotional environment on the course of schizophrenia comes from Ellen Corin's (1990) research in Montreal on "positive social withdrawal." Patients who regularly inhabit behavioral environments with few social demands evidence less psychotic symptomatology and a greater personal functioning.

Emotion and Major Depressive Disorders

When viewed cross-culturally, depression is more commonly manifest in somatic than in psychological forms (Kleinman 1986, 1988a; Kleinman and Good 1985). This finding necessarily calls into question the validity of DSM symptoms such as "depressed mood" or "loss of pleasure" as pathognomonic symptoms of the disorder. Cultural propensities toward "psychologization" versus "somatization" are more fully reviewed elsewhere (Kirmayer 1984, 1992; Ots 1990; Kleinman 1986). Jenkins, Kleinman, and Good (1991:67) 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." A key cross-cultural question is whether the clinical-research construct of depression can validly include both somatic and psychologized forms of depressive symptomatology or whether these are better considered as essentially different disorders.

Somatized versus psychologized expressions of depressive affect suggest a cultural specificity to "sadness" and "suffering" (Kleinman and Kleinman 1991). Cultural styles of dysphoria are perhaps best understood as elements of indigenous or ethnopsychological models of emotion (Lutz 1988; White and Kirkpatrick 1985). An understanding of local ethnopsychological models of depression is crucial to specification of everyday depressive affects, on the one hand, and more severely distressing depressive states, on the other.

As pointed out by Kleinman and Good (1985), there are methodological problems in differentiating depression as emotion, mood, and disorder. The parallel observation by Sullivan has already been made for normal-range behavior and that characteristic of schizophrenia. An extension of Sullivan's approach to schizophrenia as "complex, peculiarly characterized situations" was adopted by George Brown and Tirril Harris (1978) in their studies of depression. They find that cases of depressive illness, apparently very common among working-class women in the London area, can be predicted not by individual factors but instead by a specific set of situational factors: unemployment, dilapidated housing conditions, caring for three or more small children, the lack of a confiding relationship, and the death of mother before age eleven. Taken together, these factors can be observed to produce depressive reactions in these English women. This careful empirical study provides powerful evidence for the conclusion that depression is more diagnostic of women's social and economic situations than women's psychobiological vulnerability.

The sociocultural context that may be most important to cross-cultural studies of depression is gender. The relationship between depression and gender is well known: epidemiological evidence documents that women disproportionately suffer from depression relative to men (Nolen-Hoeksema 1990). This epidemiological fact with reference to North American women has also been confirmed cross-culturally in virtually every case that has been investigated. Strickland (1992) has recently summarized these data. Jenkins, Kleinman, and Good (1991) critically review the available literature on cross-cultural susceptibility to depression to conclude that the disproportionate degree of depression among women is likely to be universal. This disturbing conclusion must be accounted for in the light of gender inequality conferring less power and status to women relative to men in both Western and non-Western countries (Miller 1993; Rosaldo and Lamphere 1974). Lower socioeconomic status also must be examined since several studies have linked adverse life events and conditions to a vulnerability to depression, with again a disproportionate effect on poor women and children (Brown and Harris 1978). Migration (of immigrants and refugees) and social change are also implicated in the onset of a major depressive episode (Farias 1991; Jenkins 1991b; Kinzie et al. 1984; Mollica, Wyshak, and Lavelle 1987; Westermeyer 1988, 1989).

Cultural variations in socialization practices, marital discord, as well as "expressed emotion" may also contribute to differential rates of depression (Vaughn and Leff 1976a; Hooley, Orley, and Teasedale 1986). In summary, there is evidence that culture plays a strong role in the formation of the experience of depressive affects and disorder, the meaning of and social response to depression within families and communities, and the course and outcome of the disorder (Jenkins, Kleinman, and Good 1991:68).

CONCLUDING REMARKS

In this chapter I have drawn together two critical but often separate areas within medical and psychological anthropology, the study of the relation between culture and emotion and the study of psychopathology, in order to suggest that there is a great deal of commonality in the conceptual issues raised by each. My argument has encompassed the methodological orientations of ethnopsychology and cultural psychology, interpersonal and intrapsychic accounts of the theory of emotion, the conceptual distinction between emotion and feeling, and the problem of continuity and discontinuity between normal and pathological. I have summarized studies of dysphoric affects and emphasized the importance of experiential accounts of the emotional distress and disorder in the context of power relations and considerations of the state construction of affect, formulated in intersubjective interpersonal terms, and premised on a relational notion of self. Finally, I have considered cultural variability in the phenomenology,

course, and outcome of two major mental disorders, schizophrenia and depression, and examined contemporary psychiatric diagnostic conventions in the light of anthropological theories of emotion.

Anthropological approaches to the study of emotion have come a great distance in a relatively short period of time. Nevertheless, we have yet to see the full development of the intersection of culture, emotion, and illness processes. Along with Western traditional views of the superiority of mind over body, there is currently a strong bias toward cognitive science. While "cognitive anthropology" has made a powerful scientific contribution to the anthropological endeavor, relatively less anthropological attention has been directed toward the full range of emotion phenomena.

I conclude with suggestions for future anthropological directions in the study of emotion. First, as feminist theory has taught us, situated knowledge of emotion will continue to be critical to avoid decontextualized accounts of the passions (Haraway 1991). Psychological and medical anthropologists have long been naturally inclined toward this end. However, as Lila Abu-Lughod (1993) and others (Brown 1991; Edgerton 1992) have recently cautioned, anthropological enthusiasm for the particular should not be allowed to obscure the likelihood of shared features of human emotional experience. Second, in contrast to studies of emotion based on lexicon, discourse, ethnopsychological category, communication, and expression, we are in rather short supply of studies based on intersubjective and experiential dimensions of culture and emotion (Hallowell 1938, 1955 was a notable exception). Signs are beginning to be observable, however, that this is about to change (Csordas 1994; Shweder 1990a; Wikan 1990). Kleinman and Kleinman (1991:277) have recently offered a definition of experience as "an intersubjective medium of social transactions in local moral worlds. It is . . . the felt flow of that intersubjective medium." Theodore Schwartz, Geoffrey White, and Catherine Lutz (1992), who had previously endorsed a "distributive" theory of culture, now call for an "experience-processing" model of culture. Byron Good (1994) provides a compelling argument of the specific need in medical anthropology for the study of culture and experience in relation to affective and illness realities. Third, studies of emotion need to expand in scope beyond local and intrapsychic analyses and toward a concomitant consideration of state and global forces in mediating the experience and expression of emotion. Initial steps in this direction are evident in the work of Mary-Jo DelVecchio Good and Byron Good (1988) on the state construction of affect and Jenkins (1991) on political ethos. Fourth, the recent cultural interest in emotion would benefit from a renewed interest in naturalistic observation in tandem with interpretive analyses of emotion. A methodologically greater ethnographic emphasis on the interactive, nonverbal behavioral and symbolic dimensions of emotion would go far in complementing the current focus on linguistic and verbal dimensions of emotion.

NOTES

1. This chapter is a slightly adapted version of a chapter by Jenkins (1994) entitled "The Psychocultural Study of Emotion and Mental Disorder," published in *Handbook of Psychological Anthropology*, ed. P. Bock (Westport, Conn.: Greenwood Press).

2. Much of the discourse on emotion was subsumed under the rubric of "personality" studies (Rosaldo 1984; White 1992). A notable exception is Hildred Geertz's excellent 1959 article on the "vocabulary of emotion" published in the journal *Psychiatry*. Another important exception is Gregory Bateson's (1958:118) notion of ethos defined as "the expression of a culturally standardized system of organization of the instincts and emotions of the individuals."

3. The counterpart of cognition (and thought) as rational, controlled, safe, cultural, and male is obvious. The scientific suitability of these adjectival descriptors has long been assumed in anthropological and psychological discourse.

4. For theoretical discussion of culture, deviance (including psychopathology), and ambiguity, see Edgerton (1985). For review of a controversial thesis concerning the notion of societally widespread or institutionalized forms of deviance as constitutive of a "sick society," see Edgerton (1992). For a discussion of "explanatory models" of discrete illness episodes as necessarily complex, dynamic, contradictory, and ambiguous, see Kleinman (1980). Both of these theorists have been preoccupied with how culture theory can account for change, heterogeneity, and disagreement in the context of individual and subgroup variability.

5. Lutz and Abu-Lughod (1990) and Kirmayer (1992) provide thorough accounts of issues surrounding essentialist presumptions in social scientific discourse.

6. So-termed negative symptoms in schizophrenia are noteworthy by virtue of their absence: e.g., lack of appropriate affect, speech and volition.

7. The differences between the nonindustrialized and more industrialized countries are not uniform, however: only 9 percent of London patients and 11 percent of Washington patients displayed flat affect at the time of follow-up.

8. The observation of "lack of insight" as the most common symptom might be indicative of a clash between professional psychiatric and popular lay formulations of the problem (e.g., as a psychiatric, nervous, mental, or personality problem). If the psychiatric interviewer had accorded a legitimacy to popular illness categories, this "symptom" might not have been recorded so frequently. Failure to anthropologically appreciate these cross-cultural differences in what Kleinman (1980) has termed "explanatory models" can result in an array of methodological difficulties in the assessment of symptoms.

9. Alogia can also be present in relation to intellectual deficit.

10. Methodological definitions of these affects have been provided elsewhere (Vaughn and Leff 1976b). Briefly, criticism is any verbal statement indicating dislike, resentment, or disapproval. Emotional "overinvolvement" is indexed by a set of particular attitudes, emotions, and behaviors that are culturally determined to include overprotective or intrusive behaviors. Although affects of warmth and praise are also undoubtedly important to many qualitative dimensions of family life, these have yet to be significantly predictive of recovery from major mental disorder. The relationship between criticism, hostility, and emotional overinvolvement has also been found for depressive illness at even lower thresholds than for schizophrenia (Hooley, Orley, and Teasedale 1986; Vaughn and Leff 1976a).