* Tonight we will be considering the relationship, of any, between our emotions and health.

* To some extent we have already touched on this issue (e.g. Tohsts; my work on gender).

* We will examine such issues in more specific detail through the works of:

(1) Peter Freund (on dramaturgical stress);
(2) Howard Levanthal & Linda Patrick-Miller on emotions & illness

**Peter Freund: Social Performances and Their Discontents:**
The Biopsychosocial Aspects of Dramaturgical Stress

* In this paper, Freund:

- outlines how performing/ monitoring performances can be stressful
- develops and refines what he has termed “dramaturgical stress”
- views dramaturgical activities in the context of spatial metaphors.

* He proceeds as follows:

(1) He develops a “geography of emotions” & emotional relationships.
(2) Discusses the embodied aspects of emotions and social relationships;
(3) Discusses emotional communication and dramaturgical stress in intra-psychosomatic space;
(4) He examines dramaturgically stressful encounters in social-physical space

* All of this is linked to health and illness.
(i) The Geography of Emotions and Emotional Relationships:

*Goffman's work contains:

- strategies for controlling information flow across boundaries
- Spatial metaphors as illustrations in this regard
- a geography within the self, of self-other, and of inter and intra-group relationships
- a hint that an increasingly wide range of emotional activities are carried out behind the scenes of everyday life

* While Goffman didn't make space his master metaphor, Freund does:

- to examine mind, body and society relationships
- to examine the use of space for organizing information about self and others

* In Freund's view the organization of biopsychosocial and physical space is:

- used by individuals as a way of sustaining a performance
- used to establish boundaries and regulate the flow of information.

* Dramaturgical work thus involves:

- creating and maintaining boundaries between informational preserves
- regulating the flow of information across boundaries
- reading other actors’ expressions
- attempting to “penetrate” others’ informational preserves.

* Boundaries may be established not only in physical and social space but through the expressive activities of the body

* Expressive activities such as emotion work regulate the psychosocial and experienced bodily boundaries between self and others. They regulate the permeability of these boundaries and what information passes through them.
* This simultaneously somatic and symbolic management of self-other boundaries has been overlooked in the sociology of emotions.

* Many dramaturgical-emotional relationships can be represented topographically - as a map of relationships within the embodied self, and between the embodied self and others.

* Dramaturgical strategies of impression management are part of this topography that affects our conscious and unconscious subjective relationship to self and others.

**Mind-Body and Performances:**

* Various emotions are easier to read than others:
  - Some visibly linked to physiological activity;
  - Others hinted at through facial expression, posture or gestures

* Prior studies of the somatic aspects accompanying feelings have all been performed on inactive, decontextualized minds and bodies.

* The bodily aspect of emotion that can't be reduced to sensation needs to be more clearly identified.

* Emotions are not just cognitions nor are they clearly locatable in any specific sensation or biochemical change. Rather, they are *embodied* such that our entire being is actively engaged in an emotion.

* Emotions are thus a *fusion* of mutually modulating cognitive-physiological and behavioral aspects. Changes in one aspect may affect corresponding changes in another

* Relationships are in themselves sources of emotion. Situations which require co-presence occur in a field of bodily activities in which bodily activities may be geared into and detached from others.
* Emotions are variously embodied in:
  
  - one's subjectivity;
  - an internal biochemical milieu
  - in motoric activities such as posture, gesture, etc.,
  - are embedded in the field (i.e. the socio-psycho-biological-physical spaces - of social relations).

* This embodied aspect of emotion may be fruitfully conceptualized in spatial metaphors.

**Emotional Information and Psychosomatic Space:**

* Appraisals or interpretations may be essentially automatic

* The relative speed at which one grasps, perceives and interprets activity is an important dimension for differentiating levels, types of consciousness, and embodied agency.

* Emotions function as rapid and efficient modes of information processing, coordinating information perceived on a number of simultaneous levels.

* Some emotional communication may not involve cognition, but body consciousness that does not involve higher functions

* Emotion work as a dramaturgical strategy may involve consciously managing emotional expression or reshaping one's feelings, but must occur in the course of a short temporal lag.

* The appraisal activities of mind-body can occur on a number of different levels of consciousness, including our experience of others' expression

* Feelings and emotions motivate or move us. In this process, space is the site of conscious embodied experience. Moods affect its character (e.g. open/closed).
* Under certain circumstances, opposing postures may be evoked simultaneously (e.g. ambivalence, double-bind social situations).

* These are responses to contradictory dramaturgical demands and represent an acute form of dramaturgical stress. A disjuncture between:

  - the ways in which one desires to present oneself;
  - the social context which demands an opposite style of self presentation; and
  - doesn't allow the actor to leave the field

* The body may cope through spontaneous symptomatic expressions

* Some people dissociate performance from gut feelings ("emotional false consciousness"). The underlying physiological stresses remain.

* People often collusively and collectively reproduce oppressive and distressing structures, acting as their own agents of social control.

* Such responses may become fixed and in turn affect the production of feelings (e.g. depression).

* Articulates some of the mechanisms by which stratified society shapes our experiences of health and illness (and vice versa)

* This splitting of consciousness in psychobiological space facilitates the smooth functioning of hierarchical relationships while producing distress.

* Facilitates blaming the victim.

* Coping/emotion work may only work at one level: short-circuiting the signal function of emotion.
The Theatre of Inner Psychosomatic Space:

* The psychosomatic aspect of dramaturgical stress can be carried into an actor's inner psycho-somatic space:

  - previous and anticipated stressful encounters reviewed
  - accompanying somatic aspects
  - amplifying, subduing, refining or recasting arousal states.

* An experience accompanying such embodiment is a sense of containment. This depends on:

  - sociocultural factors such as forms of social control; and
  - the status relationships in which we find ourselves.

* Our experience of physical containment leads us to develop an inside-outside orientation, a sense of self and emotional boundaries. This forms the ground of our sense of security or insecurity.

* The “civilizing process” involves increasingly complex emotional/display work demanded for proper functioning in a variety of social situations.

* This results in a heightened reflexivity, a sharper self-consciousness, and a growing inner space for imagination.

* This enlargement of internal psychological space is accompanied by an increased sense of self-other boundaries.

* Emotion work and a sense of being contained in a vessel can be increasingly embodied.

* The increased reflexivity allegedly characteristic of “postmodern” actors may have some somatic aspects, including consequences for our health.
Dramaturgical Stress in Sociophysical Space:

* In our dramaturgical society, the very activity of manipulating appearances is, in itself, more stressful.

* Under what social conditions does such stress become particularly intense and chronic?

* Such stress is heightened when:
  - one perceives the face presented is somehow inconsistent with the face one tries to maintain for oneself and others.
  - there is a breach of boundaries.

* Some actors are in social spaces that make them particularly vulnerable to such stress:
  - subordinates with imposed and stressful emotion work
  - minorities
  - those who must cope with a social stigma/pass as “normal”

* In the dramaturgical work required to hide or redefine distressing feelings, new tensions are created which must also be hidden from the audience.

* Stress-related emotions arise from the anticipation that a more powerful other will invade or encroach upon a person’s self or space (e.g. abusive relationships), and often can only be expressed somatically.

* The growth of the service sector of the economy has increased the need for elaborate skills of self-presentation and emotion management - greatly increasing dramaturgical stress

* Further assisted by a tendency in our society to privatize disruptive feelings, and push them behind the scenes of everyday life (e.g. visiting professionals).
* Physical containment may support emotional containment (e.g. the availability of “backstages”).

* The social organization of physical space is related to dramaturgical competence. Social status of actors influences:

  - their degree of control over spatial arrangements
  - the ease with which one can sustain an effective performance
  - the degree of surveillance to which an actor's performance is subject
  - hence levels of stress..

* The inability of a subordinate individual to cope emotionally is often seen as a personal failure, not a systemic one.

* Even when people apparently “cope” successfully with dramaturgical stress, embodying social control in this way may produce other costs for them (e.g. health).

* Sociocultural situations in which such dramaturgical work is done influence the intensity, quality and quantity of emotional demands as well as how actors respond to them.

* Two features are particularly relevant:

  (1) the form of social control that prevails; and
  (2) the relative social positions of the actors

**Dramaturgical Stress and Health:**

* To what extent do the stressful experience influence health?

* Generally:

  - ill health results from a change in the normal rhythms of a subsystem incited by stressful experience;
- Disease occurs when a stressful experience interacts with a pre-existing regulatory disturbance or with a structural change.

* Distinction between physical and psychological problems unproductive
* Relationships between ill health, disease and stress (including dramaturgical stress) are neither linear nor unicausal.

* A conception of the body actively engaged with its internal and external environment is needed.

* One key factor is the extent to which the organisms' body is open to the world.

* There is an inevitable tension between stark, alienated individuality and absorption of self into others’ existence. The experience of this dialectic sustains our proper sensitivity to the world of others.

* Dramaturgical strategies regulate the psychosocial-biological and physical boundaries, their relative permeability or impermeability, and in general the flow of information across them.

* The ability to manage these boundaries is essential to our security, and likely to our health. It is suggested that the principles - or geography - of information exchange here are significant.

* These spatial concepts help link various levels of information exchange in biopsychological, social and physical space to understand the changing interaction of embodied actions.

**Howard Leventhal and Linda Patrick-Miller:**  
* Emotions and Physical Illness: Causes and Indicators of Vulnerability

* Views on the relationship between psychological/emotional factors and physical health:
  (1) *Causal Perspective* (i.e. emotions as mediators and/or causes of illness);
(2) *Outcome perspective* (i.e. emotions are outcomes of illness);
(3) *Indicator perspective* (i.e. emotions as indicators of systemic vulnerability to disease).

* The *causal* perspective:

- emotional processes function as antecedent determinants of illness.
- may be direct or indirect

* The *outcome* perspective:

- disease itself is the causal antecedent to emotion
- may also be direct or indirect
- important for firming up methodology of causal studies
- important in research examining the factors mediating emotional adjustment to illness
- important in demonstrating that the connections between emotion and disease are bidirectional

* The *indicator* perspective:

- proposes that conscious affective processes are indicators of the body's resources, vulnerability or strength
- need not mean anything in a causal sense

**The communicative Function and Structure of Emotion:**

* Viewing emotions in any of the three ways above doesn't necessarily mean that these are separate or discrete classifications.

* An emotional reaction can serve any one or any combination of these functions

* The relationships of emotion to disease are made possible by the structure of the underlying emotional mechanisms.
The Multicomponent, Hierarchical Structure of Emotion Mechanisms:

* Emotion theorists have made a strong case for:

(1) the multicomponent, hierarchical structure of emotion mechanisms
(2) the role of emotion in both interpersonal and intrapersonal communication.

* These help us understand:

- the bidirectional nature of the emotion-illness link; and
- why and how emotions can have indicator functions with respect to disease processes.

* Emotional processes are complex and hierarchically arranged in the following three levels:

(1) sensory-motor (the primitive emotional seeds defining the raw “feel” of primary emotions);
(2) emotion schemas (associative processes connecting and expanding the range of stimuli and responses linked to primary emotions); and
(3) a higher-order executive mechanism for verbalizing and regulating emotional experiences and their situational elicitors.

* It is reasonable to expect that patterned central nervous system activity is the basis for conscious emotional experience.

* Sustained peripheral autonomic activity can also promote physiological processes that damage organ structure and increase susceptibility to disease.

* Dissociation between processes at these three levels play an important role in the analysis of the causal and indicator functions of emotion.

Models for Direct Causation:
* Much research has focused on direct causation between emotion and disease. It is unclear, however, how well the data support this outlook.

* We will:

(1) Examine some of the major findings
(2) Consider how the indicator framework accounts for these.

* Three basic criteria appear necessary to support a direct relationship between emotion and disease:

(1) a specific emotion-disease linkage;
(2) the exclusion of potentially causal third factors; and
(3) a mechanism consistent with the known pathophysiology of the disease.

* Long-term longitudinal studies predict longevity from measures of emotional distress during adolescence and early childhood. Problems:

  - the mortality predicted results from all causes - not just disease.
  - fails to identify specific emotion-disease links nor their mechanisms
  - hints at the possibility of other factors being involved.

* The connection of Type A behavior/hostility to cardiovascular disease is another example. Problems:

  - Type A behavior is generic, and the specific emotion connected to the arterial changes was only later specified.
  - The psychophysiological pathways are complex, leaving abundant room for third factors
  - The physiological reactions accompanying anger are relatively short in duration.
  - The question of whether chronic hostility is in fact an emotion
  - Differentiation of levels suggest different interventions required

**Models for Cancer:**
* Cancers are also etiologically multifactorial and developmentally multiphasic - only considerably more so.

* Investigation of direct causal linkages between emotion and cancer is vulnerable to many of the same challenges:

  - the difficulty of making specific connections between the emotional hierarchy and the physiological hierarchy;
  - “third-factor” interpretations.

* Also important here is the degree of involvement of the immune system, and the window that this affords to view the bidirectionality of the processes.

**The Indicator Function of Emotion in a Bidirectional System:**

* The difficulty in demonstrating emotions as causes of illness contrasts with the ease with which we can see the effects of illness on behavior.

* When we become very ill with an infectious disease, our body concentrates its energy on fighting the infection, making us “sick.”

* Illness-induced moods are typically characterized by fatigue, depression or distress - both in minor and serious illnesses. This supports the indicator model of emotion.

* Studies of the relationship of affect and more severe, life-threatening illnesses are also consistent with the indicator function of affect (e.g. the association of “helplessness” and “passive acceptance” with poorer prognosis in cancer patients).

* Immune system activity is energy-consumptive and must draw upon the organism’s resources, dampening affect. Thus, emotional experience appear to be the domain for the conscious representation of physiological.

* Such mood effects are indicators of the availability of resources for
combating disease processes, and they can predict specific disease outcomes.

**New Directions: Infectious Diseases and Wound Healing:**

* Much of the difficulty in examining the causal relationship between emotion and disease can be linked to two factors:

1. the prolonged and multiphasic developmental disease course; and
2. the difficulty of adequately controlling causal agents.

* Studies of infectious disease and wound healing, hold great promise in elucidating emotion to disease causal relationships because they deal with these issues.

* Studies examining the relationship between life-stress and the development of infectious disease provide strong evidence of a link between emotion and disease.

* Similarly, researchers have demonstrated that measures of stress correspond to prolonged healing time of experimentally produced puncture wounds.

* In both cases the proposed direct causal mediator of the outcome relationship is immune function.

* These studies are impressive in their degree of experimental control and specificity of disease outcome. However, we must consider:

  - the relative strength of the causal relationship (stronger in wound healing)
  - the relative duration of stress involved
  - the fact that stress, not measures of emotion, were used

**Genes as “Third Factors” in Indirect Causation:**
* Genetic variables have been noted as possible “third factors” that might account for the presumed direct pathways from emotion to illness

* Such hypotheses are not wild speculations (e.g. recent studies on depression, dopamine receptor genes, smoking behaviors and disease)

* Genetic variables can be important “third factors” contributing to the relationship between emotion and disease through their effects on risk behaviors.

* Examination of these matters are only in the early stages:
  - genetic factors only accounted for a small percentage of the variance
  - psychological factors may mediate the relationships

* Genes in combination with environmental factors sought and created by psychological variables (e.g. selecting risk-seeking friends) may create a complex series of relationships for the promotion of disease.

* More research is needed.

**Conclusion: Emotion as Communication and the Emotion-Disease Link:**

* Emotions don't necessarily predict disease outcomes.

* Experientially elaborated, multilevel emotion systems respond to a wide variety of external and internal events and their meanings.

* Much depends upon the person and context.

* The search for direct effect, and the idea that controlling our thoughts, feelings and actions can help us reduce the risk of disease can mislead us

* Yet it can also inform us by encouraging research on the bidirectional connections between emotions and illness, linking biological and
psychological theory.

* The focus on indicators is designed to identify the important roles that psychological factors can play in this investigation, and also to discourage a single-causality model that obscures the role of emotion.

* We really need multifactorial models of the onset, development and outcome of the most prevalent life threatening diseases.