
Mental Health, Social Mirror

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Contributions of the Sociology of Mental Health for Understanding the Social Antecedents, Social Regulation, and Social Distribution of Emotion

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Introduction

While the sociology of emotion includes a number of compelling theories about the ways in which social factors influence both the experience and expression of emotion, it currently lacks a body of systematic empirical research with which to evaluate its key theories and concepts. In this chapter, I review findings from research on the sociology of mental health, which document a variety of social influences on subjectively experienced feelings and expressive behavior and which allow us to evaluate some emotion theories and concepts—particularly with respect to the social antecedents, social regulation, and social distribution of emotion in the population. However, I also discuss some ways in which theoretical developments in the sociology of emotion could enhance the sociology of mental health—especially with regard to our understanding of persistent group differences in both the experience and expression of emotional problems in the United States.

The sociology of emotion is a relatively new sub-discipline within sociology. First established as an official section of the American Sociological Association in 1986, this field of study has garnered enthusiastic interest from both micro—and macro—sociologists in a variety of substantive areas: sociologists of gender and the family, work and occupations, collective action and social movements, deviance and mental health as well as cultural, historical, medical, organizational, and political sociologists and social psychologists have all sought to enrich their understandings of their respective areas through the incorporation of emotion theories and concepts. For example, at his 2001 American Sociological Association presidential address on the evolution of human society, Doug Massey—whose own research focuses on the social demography of migration and immigration—argued that emotion is central in social life and that sociologists should turn their attention to feeling and affect (Massey, 2002). Increased sociological interest in and attention to feeling and emotion is due to a confluence of many factors, among them is the growing recognition that social life contains both rational and non-rational (i.e., emotional) forces and that individuals are both cognitive and affective beings.

However, while this relatively new field of inquiry has captured the attention of sociologists working in a variety of areas—and sociologists have increasingly recognized the centrality of feeling and emotion in a variety of aspects of social life—the sociology of emotion currently lacks a coherent body of systematic empirical work. Despite the development of a diverse and impressive set of theories about emotional experience and expression at both the micro—and macro—levels of analysis, the sociology of emotion falls short on empirical evidence with which these theories could be evaluated. The paucity of systematic empirical research in this area has been noted by both Thoits (1989) and Smith-Lovin (1995) in their excellent reviews of the field of emotion who agree that the sociology of affect is theoretically rich but limited empirically. With the exception of a handful of quantitative studies (Erickson & Ritter, 2001; Lively & Heise, 2004; Lively & Powell, 2006; Pugliesi & Shook, 1996; Ross & Van Willigen, 1996; Schieman, 1999, 2000; Simon & Nath, 2004; Sprecher, 1986; Wharton & Erickson, 1995)—many of which have based on the recent emotions module of the General Social Survey—almost all empirical work in this area has been based on small in-depth qualitative studies, which are very informative but cannot be used to adequately assess certain theoretical and substantive issues and debates.

In this chapter, I draw on findings from decades of empirical research on the sociology of mental health in order to shed light on three central but still unresolved theoretical and substantive debates in the sociology of emotion, which pertain to: (1) *the social antecedents of emotion*; (2) *the social regulation of emotion*; and (3) *the social distribution of emotion* in the United States. In particular, I review research that documents: (a) the importance of undesirable life events and chronic strains as well as other stressful social situations—such as persistent social disadvantage and inequality—in the *etiology of emotional distress*; (b) the role of *coping and social support for reducing symptoms of emotional discomfort*; and (c) *the social epidemiology of emotional disturbance* in the general population. The first part of my chapter, therefore, focuses on the contributions of the sociology of mental health for understanding the social causes, social control, and social patterning of emotion and emotional problems in the U.S.

In addition to reviewing research on mental health on the above three topics—which enhance our understanding of a myriad of social factors that influence both the experience and expression of emotion—I discuss theoretical developments in the sociology of emotion that contribute to our understanding of *persistent group differences in the manifestation (i.e., expression) of emotional problems in the U.S.*, particularly with respect to *gender, race, ethnicity, and socioeconomic status*. In the second part of the chapter, I suggest that gender, race, ethnic, and socioeconomic status variations in rates of emotional problems as well as people's emotional responses to stressful social situations may be due to important group differences in norms and beliefs about the appropriate experience and expression of emotion.

I conclude the chapter with a brief discussion of broad themes regarding the complementarity of theory and research on mental health and emotion. The sociology of mental health provides both an extensive and coherent body of empirical evidence

with which several theories about emotion can be evaluated. At the same time, concepts, theories, and insights from the sociology of emotion could (and in my opinion should) be used to enrich our understanding of the social psychological mechanisms that underlie the development and persistence of mental health problems in the U.S. and group differences therein. Given their many points of overlap, it is ironic that there has been little effort to utilize theory and research from the sociology of mental health to inform theory and research on the sociology of emotion and vice-versa. *This chapter represents an attempt to integrate these separate yet highly interrelated areas of sociological inquiry.*¹ Before turning to my discussion of some overlapping and crosscutting themes in the sociologies of mental health and emotion, the following three cautionary notes are warranted.

First, while sociological theories about emotion focus on individuals' everyday feelings and expressive behavior, sociological research on mental health focuses on symptoms of emotional distress—particularly symptoms of depression and anxiety—which are considered to be *moods or affective states* rather than *emotions per se*. The research on mental health on which I draw, therefore, speaks more directly to the development and persistence of *emotional problems* among persons than to their immediate and short-term *feelings and emotions*. However, because feelings of sadness, loneliness, hopelessness, anxiety, worry, and fear are key components of both symptom scales and psychiatric diagnoses of emotional problems such as depression and anxiety, sociological research on mental health provides a window into some fundamental emotion processes that are at the center of theoretical and substantive debates about the experience and expression of everyday feelings in the general population.

It is important to mention that since symptom scales and psychiatric diagnosis of depression and anxiety are partially based on the emotions mentioned above, they actually tap into some of the same feelings that have captured the attention of emotion researchers. Indeed, it is possible, if not likely, that the experience of frequent and persistent distressing emotions underlie the development of these milder mental health problems. Although I cannot say whether these same emotions contribute to serious mental illness such as schizophrenia and personality disorders, Thoits (1985) argued that non-normative emotions and emotional displays are central in the *labeling* of serious mental illness. Her informal analysis of DSM-III diagnostic criteria revealed that "inappropriate emotional states or displays are essential defining features of 45.7% of a total of 210 disorders and are associated features of 64.8% of these disorders" (p. 224). Nevertheless, because I draw mainly on studies of milder forms of mental health problems such as depression and anxiety, keep in mind that my discussion of research on mental health and emotion does *not* apply to serious mental illness.

¹ This is not to say that scholars have not worked at the intersection of the sociologies of mental health and emotion. Braburn's (1969) pioneering work and Thoits' (1984a, 1985, 1992a) later exemplary work provide excellent examples of the ways in which theory and research on mental health inform, enrich, and extend theory and research on emotion and vice versa.

Second, because most sociological research on mental health focuses on symptoms of *emotional distress* rather than on symptoms of *emotional well-being*, much of my discussion is necessarily limited to the experience and expression of *negative feelings* and emotions. I do not assume—as mental health scholars sometimes do—that the absence of negative feelings (or the absence of symptoms of emotional distress) is equivalent to the presence of positive feelings (or the presence of symptoms of emotional well-being). In his early study of the structure of psychological well-being, Bradburn (1969) found that positive and negative affect represent two separate and independent dimensions of psychological well-being. He also found that positive and negative feelings (and, by extension, positive and negative mental health) have different etiologies and are related to different things.² Since positive and negative feelings are not merely two sides of a continuum of emotional health and emotion is restricted to negative feelings and symptoms of emotional distress.

Finally, while the empirical findings on the social antecedents, regulation, and distribution of emotion that I discuss may apply to persons residing in other industrialized (and possibly non-industrialized) societies, the literature I draw on is based largely on studies conducted in the U.S. and, therefore, cannot be generalized to the emotions of and emotion processes among persons residing in other cultural contexts. Cross-cultural work on emotion and mental health finds considerable cultural variability in both the experience and expression of emotion and psychiatric illness (see Kleinman [1986] for a comparative psychiatric study in China; Scherer, Wallbort, & Summerfield [1986] for a cross-cultural study of emotional experience across several European countries, and Kleinman & Good [1985]). Evidence from anthropological and historical studies of emotion and mental health also strongly suggests that there is cultural variation in the social situations individuals perceive as stressful and which are emotionally distressing; for example, while the death of a loved one in the contemporary U.S. is stressful

² Interestingly, Bradburn (1969) found that interpersonal and role-related problems are related to negative affect, whereas social participation and affiliation are associated with positive affect. These findings differ somewhat from the predictions of Kemper's social interactional theory of emotion (1978, 1990) that I will elaborate on later, which claims that persons with relatively low status and power in social relationships experience more negative feelings, while those with comparatively high status and power in interpersonal relationships experience more positive feelings. It is, however, possible that interpersonal and role-related problems are associated with negative emotions because they represent declines in individuals' relative status and power in role-relationships; conversely, unproblematic social participation may be associated with positive emotions because it enhances individuals' perceptions of their relative status and power. Given these rich theoretical and empirical insights about negative and positive feelings, it is unfortunate that sociological research on mental health focuses only on symptoms of emotional distress rather than on symptoms of both emotional well-being and emotional distress as Bradburn did over three decades ago. For a rare example of recent research on mental health that focuses on negative and positive well-being, see Keyes (2002).

and emotionally distressing (and is associated with negative feelings such as sadness and grief), this does not appear to be the case in high mortality societies where death is a frequent occurrence and common feature of social life (Aries, 1981; Lofland, 1985). A pivotal question for future research on both emotion and mental health is whether the social factors that are closely associated with negative emotions and emotional distress (and positive emotions and emotional well-being) in the U.S. are the same or different in other, particularly non-western, societies.

Contributions of the Sociology of Mental Health for Understanding Emotion

The Social Antecedents of Emotion

Along with their social science colleagues in anthropology, history, and psychology (e.g., Brody, 1999; Corrigan, 2002; Kleinman, 1986; Kleinman & Good, 1985; Lazarus & Folkman, 1984; Lutz, 1988; Lutz & White, 1986; McMahon, 2006; Rosaldo, 1980, 1984; Schachter & Singer, 1962; Scherer, et al., 1986; Seligman, 2004; Shields, 2002; Stearns & Stearns, 1986), emotions scholars in sociology argue that there is a strong social basis of emotion, and that social situations influence people's feelings and expressive behavior (e.g., Gordon, 1981; Hochschild, 1975, 1979, 1983; Lively & Heise, 2004; Short, 1979; Simon & Nah, 2004; Smith-Lovin, 1995; Thoits 1985, 1989). Most, if not all, sociological theories about the social antecedents of emotion assert that social situations are *crucial* for individuals to have an emotional experience and influence whether they experience positive or negative feelings. As a case in point, Kemper's (1978, 1990) social interactional theory about emotion argues that decrements in individuals' status and power in social relationships produce negative emotions, while increments in their relationship status and power contribute to positive feelings. In contrast, Heise's (1979) affect control theory posits that social situations that disconfirm people's social identities result in negative feelings, whereas social situations that confirm their social identities lead to positive emotions (also see Smith-Lovin, 1990; Smith-Lovin & Heise, 1988).

The importance of social situations for shaping individuals' feelings and emotions is nowhere more evident than in current definitions of emotion. While there are numerous definitions of emotion with some important differences between them, most current ones in sociology emphasize four distinct but interrelated elements—among them the social situation. Contemporary emotions theorists generally agree that emotions involve complex combinations of: (1) physiological (i.e., bodily) sensations; (2) cognitive appraisals of social situations; (3) expressive gestures or emotional behaviors; and/or (4) cultural meanings, definitions, and labels.³

³ See Thoits (1985, 1989) for this particular formulation of emotion and Schachter and Singer (1962) for an earlier two-factor theory of emotion, which also emphasizes the importance of social situations for feelings and emotions.

However, while they assume that social situations influence whether or not people experience an emotion and shape the type of emotion they experience (as well as contribute to both the intensity and duration of the emotion), sociologists of emotion have ironically not specified *which* situations are most likely to elicit emotional responses from persons (for exceptions, see Heise [1979] and Smith-Lovin [1987]). With the exception of a handful of in-depth qualitative studies of specific emotions such as anger (e.g., Stearns & Stearns, 1986; Tavris, 1982;), love (e.g., Cancian, 1987; Simon, Eder, & Evans, 1992; Swidler, 1980, 2001), gratitude (Hochschild, 1989), sadness (e.g., Karp, 1996; Kleinman, 1986; Kleinman & Good, 1985), sympathy (Clark, 1987, 1997), grief (Lofland, 1985), and shame (Scheff, 1990), there has unfortunately been little research that has systematically assessed individuals' negative (or for that matter positive) emotional reactions to various social situations.⁴

Decades of research on the sociology of mental health—particularly on the etiology (or causes) of emotional problems—have identified several critical emotion eliciting situations. In fact, most, if not all, research on mental health conducted from a stress process theoretical paradigm has focused on specifying those social situations that individuals perceive as stressful and are emotionally distressing. Dozens of studies document that undesirable life events, chronic strains, and other stressful social situations are associated with elevated levels of emotional distress and contribute to the onset and persistence of emotional disturbance among persons. This research also finds that socially disadvantaged persons—such as those with low levels of education and income, the unmarried, women, and racial and ethnic minorities—report greater exposure to undesirable events and chronic strains than their socially advantaged peers.

Life Events

A considerable body of work in this area has focused on the impact of life events on both symptoms of emotional distress and psychiatric disorders, particularly depression and anxiety, in the general population of adults and more recently adolescents (e.g., Aneshensel, 1992; Aneshensel, Rutter, & Lachenbruch, 1991; Avison & McAlpine, 1992; Brown & Harris, 1978, 1989; Dohrenwend & Dohrenwend, 1974; Gore, Aseltine, & Colten, 1992; Thoits, 1995b). In an effort to sample the “universe of stressors” (Aneshensel, 1992; Turner & Lloyd, 1999;

Turner, Wheaton, & Lloyd, 1995; Wheaton, 1994, 1999), life events research now includes a large number and wide range of events that people experience over the life course. Although researchers find that the magnitude of the association between exposure to eventful stress and emotional disturbance is relatively modest (see Aneshensel [1992] and Thoits [1995b] but also Turner et al., [1995]), it is clear that certain types of events—especially undesirable, uncontrollable, and unpredictable (or non-normative) ones—are perceived as highly stressful and are emotionally distressing (Aneshensel, 1992; Thoits, 1995b). Among the most problematic of these events for depression and anxiety are those involving loss such as the loss of a job, divorce, and death of a loved one (e.g., Kessler, Turner, & House, 1989; Menaghan & Lieberman, 1986; Simon, 2002; Thoits, 1983; Umberson, 2003; Wortman, & Kessler, 1992; Wheaton, 1990).

Some of these events (e.g., a job loss or divorce) may be emotionally harmful because they accompany decrements in people's status and power in social relationships as Kemper's social interactional theory about emotion argues. Alternatively, loss and other types of undesirable events may be emotionally damaging because they disconfirm person's social identities as Heise's affect control theory posits. It is, of course, equally possible that these undesirable life events are emotionally distressing simply because they threaten individuals' sense of emotional and material (i.e., financial) security. In any case, findings from this research strongly suggest that people respond to undesirable life events with an array of negative feelings such as sadness, loneliness, hopelessness, anxiety, worry, fear, and possibly anger, frustration, insecurity, embarrassment, humiliation, and shame. Extending these insights, this research also suggests that people may respond to desirable life events—especially controllable and predictable (or normative) ones such as marriage, the birth of a child, a graduation, promotion, or new job—with a variety of positive feelings including happiness, satisfaction, contentment, security, joy, excitement, and pride as well as symptoms of emotional well-being. It would be useful for future research on life events to investigate these possibilities—particularly the degree to which desirable events contribute to the development and persistence of emotional well-being.

Chronic Strains

In addition to identifying life events that are associated with elevated levels of emotional distress and the onset of psychiatric disturbance, mental health researchers have examined the role and significance of chronic strains for the development and persistence of emotional problems, particularly depression and anxiety, in the general population. In contrast to eventful stressors, which are discrete social situations that often involve a role or status change or transition, chronic stressors refer to situations that are part of routine social life and are ongoing and recurrent (Pearlin, 1989; Pearlin & Lieberman, 1987; Pearlin, Menaghan, Lieberman, & Mullan, 1981). Since they are rooted in everyday social life, chronic strains encompass a wide range of social situations and circumstances that individuals perceive as stressful—including conflicts in (and

⁴ Similar to their mental health colleagues, emotions researchers in sociology tend to study negative rather than positive emotions. With the exception of research on love noted above and some limited work on happiness (e.g., Bradburn & Caplovitz, 1965), most sociological studies of specific emotions have examined negative feelings such as anger, sadness, grief, and shame. The almost exclusive scholarly focus on negative affect may reflect an underlying cultural preoccupation with negative rather than positive feelings. Consistent with this idea, Easterbrook (2003) who is an economist recently argued that despite tremendous progress in a variety of aspects of social (including economic) life, there has been a steady decline in happiness in the U.S. over the past 50 years. Also, see McMahon (2006) for an interesting description and analysis of the history of happiness in western thought and society.

between) work and family roles and relationships, financial difficulties, health problems or disability, challenges associated with providing on-going care to dependent or ill family members, prejudice and discrimination, as well as social inequality and disadvantage. An accumulation of studies now document that persistent and recurrent stressors are major precursors of emotional disturbance (e.g., Aneshensel, 1992; House, Landis, & Umberson, 1988; Liem & Liem, 1978; Ross & Huber, 1985; Ross & Mirowsky, 1989; Thoits, 1995b; Wheaton, 1990, 1994). Research further shows that exposure to chronic strains is more strongly associated with emotional distress than exposure to eventful stressors (Aneshensel, 1992; Avison & Turner, 1988; Turner et al., 1995). Several scholars have noted that a reason why undesirable life events are causally related to emotional problems is because they usher in a host of chronic challenges and difficulties for persons (e.g., Aneshensel, 1992; Mirowsky & Ross, 2003; Pearlin, 1989; Thoits, 1995b; Wheaton, 1983, 1990).

Here again, it is possible that chronic strains are emotionally distressing because they decrease individuals' perceptions of status and power in social relationships or disconfirm their social identities as Kemper and Heise argue, respectively. There is actually some support for the idea that certain situations (e.g., having an employed wife) are emotionally disturbing because they reduce individuals' perceptions of power and control in social relationships (Rosenfeld, 1989; Ross, Mirowsky, & Huber, 1983). There is also some evidence that chronic strains in valued role domains are highly stressful and distressing because they threaten role-identities that are salient to persons (see Simon [1992] but also Thoits [1995c] who does not find support for the identity-salience hypotheses with respect to life events). Whatever the exact underlying theoretical mechanism is, findings from this research strongly suggest that people respond to chronic strains with an assortment of negative emotions including sadness, loneliness, hopelessness, anxiety, worry, and fear, and possibly anger, frustration, insecurity, embarrassment, humiliation, and shame. This research also suggests that individuals may respond to on-going social situations that either bolster their perception of status and power, confirm their social identities, or simply increase their sense of emotional and material security with a host of positive emotions such as happiness, satisfaction, contentment, security, excitement, joy, and pride. It would be helpful for research on chronic strains to examine these possibilities, especially the extent to which on-going positive social situations contribute to positive feelings and the development of long-term emotional well-being.

Taken together, research on the etiology of emotional distress has identified a large number and wide range of social situations that influence the development and persistence of emotional problems and which undoubtedly precipitate a sequence of negative feelings among people. Indeed, this research demonstrates that exposure to stressful life events and chronic strains explain some of the variance in emotional distress in the population (e.g., Aneshensel et al., 1991; Dohrenwend & Dohrenwend, 1976; Kessler, 1979; Mirowsky & Ross, 2003; Turner et al., 1995). Simply stated, sociodemographic and social status differences in the prevalence of emotional problems and psychiatric disorders in the U.S. are partially due to

sociodemographic and social status differences in exposure to stressful social situations. Emotions scholars should draw on this useful typology of undesirable life events and chronic strains in order to pinpoint the social situations that underlie decrements in individuals' power and status in social relationships and that disconfirm their social identities—which have both been hypothesized to increase negative feelings and emotions.

However, at the same time that the sociology of mental health contributes to our understanding of the social antecedents of emotion, theory and research in this area would benefit from the addition of a broader range of life events and on-going social situations (including life-affirming desirable events and on-going positive situations) as well as a broader range of emotional outcomes—particularly measures of emotional well-being. Consistent with Aneshensel and colleagues' (1991, 1992, 1996) argument about the need for research to consider multiple sources and outcomes of stress, the inclusion of measures of emotional well-being would allow mental health researchers to more fully capture the ways in which social experiences affect the emotions and health of individuals in the population. This would also permit them to directly assess whether the absence of symptoms of emotional distress is different from the presence of symptoms of emotional well-being as Bradburn (1969) argued and found some time ago.

The Social Regulation of Emotion

In addition to developing innovative theories about the social antecedents of emotion, sociologists of emotion have developed provocative theories about the *social regulation of emotion*. Most notable among these is Hochschild's (1975, 1979, 1982, 1988) seminal theoretical work on emotion management. In this cultural theory about emotion, Hochschild argues that societies contain cultural beliefs about emotion, which give rise to social norms about appropriate emotional experience and expression. She claims that cultural beliefs about emotion influence individuals' emotions vis-à-vis feeling and expression norms, which specify the emotions they should and should not feel and express both in general and in specific settings. Feeling rules are social norms that specify the appropriate type, intensity, duration, and target of subjectively experienced feelings. Expression rules are social norms that regulate the type, intensity, duration, and target of emotional behavior or affective displays. According to Hochschild, feeling and expression rules are standards by which we judge our own and other people's emotions; when our feelings and expressions depart from emotion norms, we often engage in emotion management, expressions management, or both in order to create a more appropriate response. She emphasizes that individuals learn social norms about emotion through the same processes and in the same contexts in which they learn other normative information, which is in everyday social interaction with parents, siblings, teachers, and peers. That is, people acquire cultural knowledge about socially permissible and unacceptable feelings and affective behavior from childhood throughout adulthood vis-à-vis emotional socialization.

As the most influential of the sociological theories about emotion (Smith-Lovin, 2003), there is now a significant body of work that has elucidated the processes through which individuals manage their own and other people's emotions (e.g., Erickson & Ritter, 2001; Erickson & Wharton, 1997; Frude & Goss, 1981; Gatta, 2002; Harlow, 2003; Hochschild, 1983, 1988; Leavitt & Power, 1989; Leichter, 1993; Lively, 2000, 2002; Lois, 2003; Pierce, 1995; Pollak & Thoits, 1989; Simon et al., 1992; Smith & Kleinman, 1988; Thoits, 1995a). This research has also identified the content of feeling and expression norms and documented emotional socialization in a variety of social contexts.⁵ However, while these studies shed light on emotion management (as well as emotion norms and emotion socialization) in various social settings, they provide little insight into the social regulation of emotion in the general population.

For instance, we still do not know the extent to which individuals manage their non-normative (or "deviant") emotions and whether there are sociodemographic and social status variations in the use (and effectiveness) of emotion management. Once again, decades of research on the sociology of mental health—particularly on *coping and social support*—demonstrate that people regulate (i.e., manage) their own and other's negative emotions through a variety of coping and social support resources and strategies. This research also shows that coping and social support are not randomly distributed in the population; certain groups of people—including those with lower levels of education and income, the unmarried, racial and ethnic minorities, and (depending on the specific type of resource and strategy) women—have fewer coping and social support resources and use less effective coping strategies than others with which to manage their negative feelings.

Coping Resources & Strategies

Because emotional distress and psychiatric disturbance are not inevitable consequences of exposure to undesirable life events and chronic strains, researchers have sought to identify social factors that intervene between stressful social situations and people's emotional reactions to them. To date, researchers have identified a number of coping and social support resources and strategies that mediate and

moderate the relationship between stress exposure and emotional disturbance (Pearlin & Schooler, 1978). For example, studies show that *coping resources*—which refer to individuals' personal characteristics such as their sense of control or mastery and self-esteem—directly reduce symptoms of emotional distress as well as buffer the deleterious effects of stress exposure (Murovsky & Ross, 1990; Turner & Noh, 1983; Turner & Roszell, 1994). Similarly, studies find that *coping strategies*—which refer to people's actual behavior such as problem-focused and emotion-focused coping efforts—have both direct and indirect effects on emotional problems that are associated with eventful and chronic stressors (Mentaghan, 1983). Men and women turn to these coping strategies in order to deal with demands of stressful social situations themselves as well as their emotional reactions to them. Not surprisingly, studies indicate that problem-focused coping is most efficacious for dealing with the demands themselves, while emotion-focused coping is most efficacious for dealing with one's emotional reactions to difficult life events, situations, and circumstances (Thoits, 1991a, 1995b).⁶ For these and other reasons, coping researchers have concluded that people often use multiple strategies when coping with acute and chronic stressors.⁷

Since coping resources and strategies reduce symptoms of emotional distress and buffer the harmful emotional effects of life stress, it is likely that they also affect individuals' immediate and short-term negative emotional reactions to social situations more generally. For example, people who believe that they have control over life outcomes, who have high self-esteem, and who have an active coping style (i.e., who regularly use coping behaviors) may be less likely to experience negative feelings than those who lack coping resources and have a passive coping orientation. When faced with a demand, these persons may also experience negative emotions with less intensity and for a shorter duration than those who lack resources. Moreover, the negative feelings they experience may not as readily develop into chronic feelings of emotional distress and emotional problems.

However, while all coping resources and strategies are likely to be important for reducing negative feelings, emotion-focused coping efforts may be particularly significant. In her highly innovative work on this topic, Thoits (1984a, 1985) argued that emotion-focused coping operates in much the same way as emotion management (also see Folkman & Lazarus, 1985 and Lazarus & Folkman, 1984).

⁵ Following Hochschild's (1983) seminal work on flight attendants, most sociological research on emotion management has been conducted at the workplace (Erickson & Wharton, 1997; Erickson & Ritter, 2001; Gatta, 2002; Hochschild, 1983; Leichter, 1993; Lively, 2000, 2002; Pierce, 1995), although there has been some work in the family (Frude & Goss, 1981; Hochschild, 1989; Wharton & Erickson, 1995). There is also some research on emotion norms, emotion socialization, and emotion management in educational institutions such as professional school (Cahill, 1999; Smith & Kleinman, 1989), college (Harlow, 2003), middle-school (Simon et al., 1992), and preschool (Leavitt & Powell, 1989; Pollak & Thoits, 1989) as well as among "deviant" subgroups including sexual minorities (Schrock, Holden, & Reid, 2004) and the disabled (Cahill & Eggleston, 1994). Potentially fruitful areas for this genre of work are psychiatric and other types of hospitals as well as athletic, political, and military organizations. See Lois (2003) for an interesting investigation of the emotion culture of a search and rescue organization.

⁶ It is important to emphasize that coping resources such as a sense of control and self-esteem are *intra-individual* characteristics of persons that inadvertently protect them from the negative emotional effects of stress. In contrast, coping strategies such as problem-focused and emotion-focused coping refer to individual's actual efforts to manage specific situational demands, which they appraise as taxing (Lazarus & Folkman, 1984; Thoits, 1995a).

⁷ Studies further indicate that people use a greater number of coping strategies when they appraise the situation as severe (Cronkite & Moos, 1984; Folkman & Lazarus, 1980) and that problem-focused coping is more likely when stressors are appraised as controllable, while emotion-focused coping is more likely when they are appraised as uncontrollable (Coyne, Aldwin, & Lazarus, 1981; Folkman, 1984; Folkman & Lazarus, 1980, 1985; Stone & Neal, 1984; Thoits, 1991a).

Utilizing concepts from the sociology of emotion, she showed that people cope with persistent and recurring negative emotions—especially *non*-normative and *distressing* feelings—in a number of different social contexts through emotion management by suppressing the negative feelings they have and replacing them with more appropriate or pleasant (i.e., positive) emotions. These findings suggest that individuals routinely *transform* their emotions so that they are more consistent with cultural emotion norms. Coping researchers should pay greater attention to both the use and effectiveness of emotion management for reducing feelings of emotional distress as well as for increasing feelings of emotional well-being among persons in the population.

Social Support

An additional psychosocial resource that sociologists of mental health frequently study is social support, which includes both functional and structural support. Unlike the coping resources and strategies discussed above—which consist of individuals' *own* response to managing stressful situations and their emotional reactions to them—functional support refers to "functions performed for the individual by significant others such as family members, friends, and coworkers" (Thoits, 1995b: 64). Three types of functional support have been identified in the literature: significant others provide instrumental, informational, and emotional support (House & Kahn, 1985).⁸ Moreover, functional support may be received or perceived; people may actually receive these various forms of assistance from others or simply perceive that such assistance is available if needed. One of the most interesting findings of this research is that perceived emotional support is associated with fewer symptoms of emotional distress than received social support (Wehington & Kessler, 1986).⁹ Similar to research on coping resources discussed above, studies show that perceived emotional support directly reduces emotional disturbance as well as buffers the damaging emotional effects of undesirable life events and chronic strains. Studies further indicate that the most efficacious type of social support in the face of life stress is simply having an intimate confiding relationship (Cohen & Wills, 1985).

In contrast to functional support, structural support refers to the social networks in which people are embedded and the characteristics of these networks—such as the number of social relationships they have and the frequency with which they have contact with these persons; structural support is the degree to which

⁸ As the terms imply, instrumental support refers to concrete services or resources that others provide to individuals who are dealing with stress, including such things as childcare, meals, transportation, housing, and money. Similarly, informational support refers to information that others provide, while emotional support refers to the understanding and sympathy (i.e., the emotional assistance) they give.

⁹ Paralleling the ideas in Kemper's social interactional theory of emotion, Wehington and Kessler (1983) claim that a reason why the receipt of social support is not as effective for reducing symptoms of emotional distress as the perception of social support is because it results in declines in power and status in the social relationship.

individuals are socially integrated. Although structural support (including the size of the social network) is associated with fewer symptoms of emotional distress, research indicates that it does not buffer the negative emotional impact of stressors on persons (Cohen & Wills, 1985; House et al., 1988).

Since social support mediates (and sometimes moderates) the relationship between stress exposure and emotional disturbance, it may also affect individuals' immediate and short-term negative emotional responses to stressful social situations. It is possible, if not likely, that social support—especially *emotional* support—operates in much the same way as do coping resources and strategies with respect to the social regulation of negative emotions. For example, people with supportive social networks may experience less frequent negative emotions to begin with. Additionally, either the perception or receipt of all forms of assistance—including instrumental, informational, and particularly emotional support—may reduce negative feelings that tend to arise in stressful social situations. Emotional support from a partner, close friend, relative, and/or coworker may also be directly involved in emotion management; persons who have emotional support may be better able to manage their own negative feelings when dealing with stressors and supportive others may help them manage their emotions, their affective displays, or both.

In her seminal work in this area, Thoits (1984a, 1985, 1986a) identified several techniques of interpersonal coping assistance—many of which involve emotion-focused coping. It appears that supportive others help individuals manage their distressing emotions by: (1) reinterpreting situations so they are less negative or threatening; (2) distracting them so they do not dwell on the stressful situation or the unpleasant emotions; (3) helping them alter their physiological sensations with substances, prayer, meditation, and physical exercise; as well as (4) encouraging them to actually transform their current feelings by suppressing the unpleasant emotions they are experiencing and invoking more positive emotions. Inspired by Thoits' pioneering work on this topic, several in-depth qualitative studies of emotion management, especially interpersonal and reciprocal emotion management, have elucidated the content of emotion-focused social support in a variety of social settings, contexts, and relationships (Francis, 1997; Lively, 2000; Schroek, Holden, & Reid, 2004; Slaske, 1996; Thoits, 1995a). Social support researchers should examine the various ways in which supportive members of people's social networks help them reduce their negative emotions and perhaps increase their positive feelings vis-à-vis emotion management.

Taken as a whole, research on the sociology of mental health has identified a variety of coping and social support resources and strategies through which individuals regulate their own (and other people's) distressing emotions. Since they directly reduce feelings of emotional discomfort as well as buffer the emotional impact of stressors, it is likely that coping and social support also help persons regulate their immediate and short-term negative emotional responses to a plethora of stressful social situations. Emotion-focused coping and emotional support may be particularly important for the management of negative feelings. Not surprisingly, with the exception of the availability of supportive emotional relationships—which

women report the same as or more of than men—stress theory predicts and mental health research generally finds that the epidemiology of coping and social support closely corresponds to the epidemiology of emotional distress and psychiatric disorder in the population (e.g., Mirowsky & Ross, 2003; Pearlin & Schooler, 1978; Pearlin, 1985; Thoits, 1987, 1995b; Turner & Marino, 1994; Turner & Noh, 1983). That is, socially disadvantaged persons—including those with lower levels of education and income, the unmarried, women, and racial and ethnic minorities—have fewer coping resources and use less effective coping strategies than their socially advantaged peers. Interestingly, the observation that women are more likely than men to both perceive that they have emotional support and use emotion-focused coping strategies (Simon & Nath, 2004; Thoits, 1991b) contradicts stress theories' explanation of women's higher rates of emotional distress but provides support for Hochschild's (1983) assertion that emotion management is more common among women than among men. Emotions scholars would be wise to draw on this exhaustive inventory of coping and social support resources and strategies in order to broaden their knowledge about the multitude of ways in which individuals manage their own (and others') negative feelings.

Nevertheless, at the same time that research on coping and social support contributes to our understanding of the social regulation of emotion in the general population, it would be enhanced by following Thoits' lead and more explicitly examining the degree to which people manage their own and others' negative (and possibly positive) emotions. By doing so, mental health scholars could begin to identify social norms that underlie individuals' understandings of and beliefs about appropriate and inappropriate feelings and expressive behavior.

The Social Distribution of Emotion

In addition to theorizing about the social antecedents and social regulation of emotion, emotions scholars have theorized about the *social distribution of emotion*. Indeed, a core insight of the sociology of emotion is that feelings are *socially patterned* and are, therefore, *not* randomly distributed in the population. For instance, Kemper's (1990) and Hochschild's (1979) influential structural theories about emotion posit that individuals' social location influences both their subjectively experienced feelings and their affective behavior. Kemper argues that people with high status and power in society (i.e., those with high levels of education and income, the married, men, and white persons) experience more frequent positive emotions, whereas people with low status and power in society (i.e., those with low levels of education and income, the unmarried, women, and racial and ethnic minorities) experience more frequent negative feelings. Hochschild further claims that individuals who are employed in low status occupations not only experience more frequent negative and less frequent positive emotions, but are also the targets of other people's negative feelings.

Despite these rich theoretical insights, with the exception of a handful of recent quantitative studies (Lively & Heise, 2004; Ross & Van Willigen, 1996; Schieman, 1999, 2000; Simon & Nath, 2004; Sprecher, 1986), data limitations have

prevented emotion researchers from assessing the social distribution of emotion in the population. The few studies that exist provide support for structural theories about emotion. As a case in point, based on analyses of data from the 1996 emotions module of the General Social Survey, Nath and I (Simon & Nath, 2004) found that people with lower levels of education and household income, the unmarried, women, and ethnic minorities report negative feelings more often than those with higher levels of education and income, the married, men, and white persons. In contrast, individuals with higher levels of education and men report positive emotions more often than those with lower levels of education and women. Not surprisingly, our research also reveals sociodemographic and social status differences in the frequency with which people experience specific emotions: individuals with higher levels of education and men report more frequent feelings of calm and excitement, whereas those with lower levels of education and household income and women report more frequent feelings of anxiety and sadness. However, in contrast to the predictions of structural theories about emotion, we also found that there are no sociodemographic or social status differences in self-reports of feelings of anger and shame.¹⁰

Because symptom scales and psychiatric diagnoses of depression and anxiety include negative emotions such as sadness, loneliness, hopelessness, worry, anxiety, and fear, it should come as no surprise that the findings from Nath's and my recent research and other quantitative studies of the social structuring of emotion closely parallel findings from research on mental health with respect to the social epidemiology (i.e., the social patterning) of emotional distress and psychiatric disturbance in the general population. Dozens of studies based on both community and national samples of adults and more recently adolescents document that persons with disadvantaged social statuses—including those with low socioeconomic status, the unmarried, females, and some ethnic groups—have higher rates of certain types of emotional problems than their more advantaged peers. In fact, the search for the underlying causes of sociodemographic and social status differences in mental health problems in the U.S. is responsible for the abundance of sociological

¹⁰ Although Nath and I did not find gender differences in the frequency with which people report angry feelings, Ross and Van Willigen (1996) found that women report angry emotions more often than men. Differences between the findings of these two studies may be due to differences in the measurement of anger in these different studies, which Nath and I discuss in our paper. However, although they do not report more frequent feelings of anger than men, our study revealed that women report that their anger is both more intense and of longer duration than men's and that men and women differ in the ways in which they cope with (i.e., manage) their angry feelings. Consistent with Thoits' study (1991b), we found that women cope with their angry feelings by talking with others and praying to God, whereas men cope with their anger by using substances, including having a drink or taking a pill. Using these same data (i.e., the GSS emotions module), Lively and I (Simon & Lively, 2005) are currently investigating whether women's more intense and longer lasting anger play a role in their more frequent feelings of emotional distress relative to men. Our analyses indicate that these two dimensions of anger are involved in women's more frequent feelings of both sadness and anxiety and that angry feelings are associated with emotional distress.

research on both the social etiology of emotional distress and the role of coping and social support for reducing emotional discomfort that I discussed earlier.

Socioeconomic Status

Consistent with sociologists' long-term preoccupation with the ways in which social class affects individuals, groups, and societies, sociologists of mental health have documented social class differences in emotional distress. Epidemiological studies in the U.S. dating as far back as the 1930's (Faris & Dunham, 1939) consistently indicate a close association between socioeconomic status and mental health problems in the general population of adults and that all types of emotional problems (ranging from the mildest forms of emotional discomfort to the most severe forms of mental illness) are more common among persons with lower levels of education and family income and lower status occupations (e.g., Dohrenwend & Dohrenwend, 1969; Hollingshead & Redlich, 1958; Kessler, 1979; Kessler & Cleary, 1980; Link, Lennon, & Dohrenwend, 1993; Yu & Williams, 1999).

However, while the association between socioeconomic status and mental health is irrefutable, the underlying social factors that are responsible for this relationship are more elusive and continue to be the subject of debate. For example, some studies show that social causation processes are of greater significance than social selection processes for understanding socioeconomic status differences in mental health, while others find that both social causation and social selection contribute to the social class-emotional distress relationship (Dohrenwend, Levan, Shrout, Schwartz, Naveh, Link, Skodol, & Stueve, 1992; McLeod & Kaiser, 2004). Moreover, although some scholars maintain that lower class persons experience greater emotional distress because they are more exposed to acute and chronic stressors (e.g., Turner et al., 1995), others claim that deficits in coping and social support resources among the lower class (which render them more vulnerable to the harmful emotional effects of stress) are responsible (e.g., Kessler & McLeod, 1990; Pearlin & Schooler, 1978; Thoits, 1984b, 1995b). No matter which of these arguments they embrace, mental health researchers have interpreted the available evidence to mean that individuals' location in the stratification system and other structural factors influence their emotional well-being.

The fact that persons with limited educations, occupations, and financial resources report higher levels of emotional distress and are more likely to have certain types of psychiatric problems than their more advantaged counterparts closely corresponds to findings from Nath's and my study of the social distribution of emotion in the U.S. discussed above. It is worth noting that although research on mental health typically does not examine the social distribution of emotional well-being in the population, an early study showed that happiness is associated with socioeconomic status and is more frequently experienced by members of advantaged social classes (Bradburn & Caplovitz, 1965). These earlier findings are also consistent with Nath's and my recent research on emotion. In short, decades of research in the sociology of mental health provide support—albeit indirect support—for Kemper's and Hochschild's structural theories

about emotion. At the same time, findings from Nath's and my recent work and Bradburn and Caplovitz's early study illustrate that research on the relationship between socioeconomic status and mental health would benefit from the inclusion of measures of emotional well-being since it would allow researchers in this area to directly assess whether social advantaged persons actually report better mental health than their disadvantaged peers.

Marital Status

In addition to socioeconomic status, sociologists of mental health have long been interested in the relationship between marital status and emotional distress. First documented by Gove over a quarter of a century ago (Gove, 1972; Gove & Tudor, 1973), dozens of studies since then have demonstrated that unmarried persons—including both never and previously married persons such as the widowed and divorced—report more emotional problems (ranging from the mildest forms of emotional discomfort to more severe forms of mental illness) than their married peers (e.g., Barret, 2000; Kessler & McRae, 1984; Menaghan, 1989; Menaghan & Lieberman, 1986; Pearlin & Johnson, 1977; Simon, 1998, 2002; Thoits, 1986b; Umberson, Chen, House, Hopkins, & Slaten, 1992; Williams, 2003; Williams, Takeuchi, & Adair, 1992). It is worth noting that the marital status difference in emotional well-being is one of the most oft cited findings from the sociology of mental health. In fact, the greater emotional discomfort experienced by unmarried compared to married people was initially observed over one hundred years ago in Durkheim's (1951) classic study of the social basis of suicide.¹¹

However, here again, while the association between marital status and mental health is indisputable, scholars debate about the underlying social factors that are responsible for this relationship. Although numerous studies show that social causation processes are of greater importance than social selection processes for understanding marital status differences in emotional distress (Marks & Lambert, 1998; Menaghan, 1989; Menaghan & Lieberman, 1986; Simon, 2002; Thoits, 1986b), other studies find that social selection processes also contribute to this relationship (Mastekaasa, 1992; Menaghan, 1985; Simon, 2002). For example, longitudinal research shows that depressed persons are more likely to become divorced than non-depressed persons. Moreover, as

¹¹ Although much less studied than marital status, sociological research on mental health also documents employment status differences in emotional disturbance (Lennon, 1999); not surprisingly, unemployed persons report more mental health problems than their employed peers. However, while married and employed persons report fewer symptoms of emotional distress, studies also show that parenthood does *not* confer a mental health advantage for individuals. Based on a nationally representative sample of adults, Evenson and I (Evenson & Simon, 2005) found that recently found that there is no type of parent who reports less depression than non-parents. We do, however, find considerable variation in depression among parents and that certain types of parenthood are associated with more depressive symptoms than others.

in the case of socioeconomic status differences in mental health, some researchers argue that unmarried persons report greater emotional distress because they are more exposed to acute and chronic stressors (Pearlin & Johnson, 1977; Thoits, 1986), whereas others claim that deficits in coping and social support resources among the unmarried (which render them more vulnerable to the harmful emotional effects of stress) are responsible for their comparatively poorer mental health (Kessler & Essex, 1982; Thoits, 1984b, 1995b). Whichever explanation they embrace, mental health scholars agree that marital status represents a structural location in systems of inequality in the U.S. that influences people's emotional well-being. As such, epidemiological findings on marital status—which dovetail findings from Nath's and my research on the social distribution of emotion in the U.S.—also support Kemper's and Hochschild's structural theories about emotion. Although our study revealed that married people do *not* report more frequent positive emotions than their unmarried peers, future research on the relationship between marital status and mental health should nonetheless examine symptoms of emotional well-being as well as symptoms of emotional distress in order to assess whether the married actually experience better mental health than unmarried persons.

Before leaving the topic of marital status differences in emotional distress, one additional point is in order: in his influential sex-role theory of mental illness, Gove (1972; Gove & Tudor, 1973) argued that the emotional advantages of marriage are only available to men and that marriage is emotionally *disadvantageous* for women. Gove attributed married women's relatively higher rates of emotional distress in modern industrial societies to their social roles in the family, which he claimed were unrewarding and highly stressful. While these ideas are provocative, in a recent empirical test of Gove's theory I found that the emotional benefits of marriage apply to men *and* women when male and female types of mental health problems are *both* considered (Simon, 2002). This finding reflects the more general finding from epidemiological research that men and women manifest (i.e., *express*) emotional distress in gender-specific ways (Dohrenwend & Dohrenwend, 1976)—a finding to which I now turn.

Gender

Motivated in large part by Gove's sex-role theory of mental illness, mental health researchers have also focused on the relationship between gender and emotional disturbance. Because most studies on this topic are based on symptoms of generalized distress, depression, and anxiety (which are more common among women), and do *not* include symptoms of disgust that are more common among men (such as antisocial personality disorders and substance problems), scholars have long assumed that women have higher rates of mental health problems than men. To explain women's elevated levels of emotional distress, researchers emphasize their greater exposure to role-related stress (e.g., Aneshensel et al., 1991; Gore & Mangione, 1983; Kessler & McRae, 1984; Menaghan, 1989; Mirrowsky & Ross, 2003; Ross & Huber, 1985; Simon, 1992, 1995; Thoits, 1986b) as well as their

greater vulnerability to stress due to their lack of coping and social support resources (e.g., Kessler, 1979; Rosenfield, 1989; Thoits, 1984a).

However, while these explanations are compelling and have advanced our understanding of the relationship between gender and mental health in the U.S., epidemiological studies of life-time and recent prevalence rates of mental disorders among adults document that men and women experience *different types* of emotional problems; while women have higher rates of affective and anxiety disorders (and their psychological correlates of non-specific emotional distress, depression, and anxiety), men have higher rates of antisocial personality and substance abuse disorders (and their psychological correlates of antisocial behavior and substance problems) (Aneshensel et al., 1991; Dohrenwend & Dohrenwend, 1976; Kessler, McGonagle, Schwartz, Blazer, & Nelson, 1993; Meyers, Weissman, Tischler, Holzer, Leaf, Orvaschel, Anthony, Boyd, Burke, Kramer, & Stoltzman, 1984; Robins, Helzer, Weissman, Orvaschel, Burke, Rieger, 1984). Moreover, studies show that gender differences in these types of emotional problems are evident in early adolescence (Avison & McAlpine, 1992; Gore et al., 1992; Rosenfield, Lennon, & White 2005; Rosenfield, Verterfuelle, & McAlpine, 2000). Based on these findings, scholars have concluded that men and women *manifest* distress with different *types* of emotional problems. In fact, epidemiologists assert that when male and female types of psychiatric disorders and mental health problems are *both* considered there are *no* gender differences in overall rates of mental illness among adults and adolescents in the U.S.

That males and females manifest emotional distress with different types of emotional problems and respond to stress with gender-typical emotional disorders strongly suggests that they also differ in the frequency with which they experience everyday negative (and positive) emotions more generally. There is some evidence of this in Nath's and my study of gender and emotion discussed above; although we found that women are not more emotional than men, women report negative feelings more often than men, whereas men report positive feelings more often than women. We also found gender differences in self-reports of specific emotions; while there are no gender differences in feelings of anger and shame, men report more frequent feelings of calm and excitement, whereas women report more frequent feelings of sadness and anxiety. Interestingly, our analyses further revealed that gender differences in the frequency of some negative feelings (as well as some positive emotions) disappear once sociodemographic and social status variables (i.e., structural factors) are held constant.

To the extent that women are structurally disadvantaged in the U.S.—and there is strong evidence indicating that they are—Nath's and my findings provide support for Kemper's and Hochschild's structural theories about emotion. However, at the same time, by documenting that males and females express emotional discomfort with different *types* of mental health problems, epidemiological studies reveal a more complex set of patterns, which provide support for *both* structural *and* cultural theories about emotion. Regardless of which theory is more accurate, it is clear from this research that future work on the relationship between gender and mental health should include a variety of measures of emotional distress (and

emotional well-being) in order to capture the ways in which males and females express emotional distress.

Race and Ethnicity

A much less studied and subsequently less understood source of variation in mental health in the U.S. is race. In general, studies that assess the mental health of minorities report few differences between blacks and whites. Both community and national epidemiological studies indicate that rates of anxiety and depressive disorders are lower for blacks than whites (Kessler, McGonagle, Zhao, Nelson, Hughes, Eshelman, Wittchen, & Kendler, 1994; Turner & Gill, 2002; Williams & Harris-Reid, 1999) and that African Americans report the same (or fewer) symptoms of emotional distress than their white peers when statistical controls for socioeconomic status are included in analyses (Kessler & Neighbors, 1986). These findings have led to the conclusion that race does not have an independent effect on mental health.¹²

Paradoxically, while African Americans do *not* have higher rates of *mental* health problems than whites, they *do* have higher rates of *physical* health problems. Even less well understood are ethnic variations in mental health; although there is too little information about Asians and Native Americans to draw meaningful conclusions at this time, rates of emotional problems are higher for Hispanics than for whites (Williams & Harris-Reid, 1999). Interestingly, the only difference in self-reports of feelings between blacks and whites that Nath and I found in our study were for anxiety. However, and paralleling epidemiological findings on race, African Americans report anxious feelings *less* rather than more often than their white peers. Research on the relationship between race and mental health, therefore, provides only limited support for structural theories about emotion. Here again, future work on this relationship should include measures of emotional well-being as well as measures of emotional distress in order to determine whether African American's actually enjoy better mental health than white persons.

Overall, sociologists of mental health have made important contributions to our understanding of the social distribution of emotion in the U.S. Epidemiological studies document that socially disadvantaged persons—including those with lower socioeconomic status and the unmarried—are more distressed than their more advantaged peers. Gender differences in mental health are more complex and depend on the type of emotional problem considered: while women have higher rates of *internalizing* emotional problems such as depression and anxiety, men have higher rates of *externalizing* emotional problems such as substance abuse. Moreover, despite their social disadvantage, African Americans do *not* report

¹² The one exception to this observation is the race difference in emotional distress among socially disadvantaged persons: African Americans with low socioeconomic status report higher levels of distress than their low socioeconomic status white counterparts (Kessler & Neighbors, 1986).

more emotional problems than white persons. Sociological research on mental health, therefore, provides some though not complete support for Kemper's and Hochschild's structural theories about emotion. Emotions researchers should make use of this extraordinary body of work to test, refine, and expand their theories about sociodemographic and social status differences in the experience of negative emotions in the general population of adolescents and adults.

However, at the same time that epidemiological research provides a window into the social distribution of negative emotions in the U.S., it would be greatly enriched by including measures of emotional well-being as well as measures of emotional distress so that mental health researchers could directly assess whether those social groups who report less distress also report greater well-being. Nath's and my recent work on the social distribution of both negative and positive "everyday" emotions in the general population of adults strongly suggest that this would be a worthwhile addition to sociological theory and research on mental health.

Contributions of the Sociology of Emotion for Understanding Group Differences in the Manifestation of Emotional Problems

Emotion Cultures, Emotion Norms, and Emotional Socialization

At the same time that sociological research on mental health sheds light on theoretical debates in the sociology of emotion regarding the social causes, social control, and social patterning of emotion, theoretical insights from the sociology of emotion enhance our understanding of persistent group differences in rates of emotional problems—particularly with respect to gender, race, ethnicity, and socioeconomic status. Although epidemiological studies document gender differences in the prevalence of certain types of mental health problems, with the exception of only a few scholars (Rosenfield, 1999; Rosenfield et al., 2000, 2006; Simon, 2000, 2002; Simon & Nath, 2004), there has been little theoretical work specifying *why* men and women *express* distress with gender-typical emotional problems. There has also been little theoretical work specifying *why* blacks report fewer emotional but more physical health problems than white persons (see Brown, Sellers, Brown, & Jackson [1999] and Williams & Harris-Reid [1999] for exceptions). Moreover, while studies show that socioeconomic status differences in exposure and vulnerability to stress help explain socioeconomic status differences in emotional disturbance, other factors may also contribute to this relationship. Theoretical developments in the sociology of emotion—especially cultural theories about emotion, which highlight the importance of emotion cultures, emotion norms, and emotional socialization—provide a conceptual framework with which to interpret group differences in the experience and expression of emotional problems in the U.S., as well as a useful direction for future research on these issues.

Recall that Hochschild's (1975, 1979, 1982) cultural theory about emotion asserts that societies contain ideological beliefs about feelings, which include cultural norms about their proper experience and expression; social norms about emotion (i.e., feeling and expression rules) specify the emotions individuals should and should not feel and express in general and in particular social settings. According to Hochschild and others (e.g., Gordon, 1981; Smith-Lovin, 1995; Thoits, 1985), feeling and expression rules provide standards by which people judge their own and others' emotions; when people's feelings and expressions depart from emotion norms, they often engage in emotion management, expression management, or both in order to create a more appropriate response. As noted earlier, a central tenet of cultural theories about emotion is that individuals learn the feeling and expression norms of their respective cultures and subcultures in social interaction with others and acquire knowledge about socially permissible and unacceptable feelings and expressive behavior throughout the life course vis-à-vis emotional socialization. In my opinion, Hochschild's compelling cultural theory about emotion can be used to understand persistent group differences in emotional distress and psychiatric disturbance in the population. Simply stated, gender, race, ethnic, and socioeconomic status differences in rates of emotional problems in the U.S. may be a function of group differences in *cultural norms and beliefs* about the appropriate experience and expression of emotion.

Gender

Drawing on these and other theoretical developments in the sociology of emotion, I have argued elsewhere (Simon, 2000, 2002; Simon & Nath, 2004) and maintain that U.S. emotion culture includes beliefs about the "proper" emotional styles of males and females as well as gendered feeling and expression rules, which specify the appropriate experience and expression of emotion for males and females. In addition to deeply held cultural beliefs that females are more emotional than males, the experience and expression of sadness is not only accepted but is expected for females, though it is considered inappropriate for males. In contrast, the experience and expression of anger is culturally appropriate for males but not for females. A consequence of gender-linked emotional socialization is that females learn to express emotional upset with internalizing emotional problems such as depression and anxiety, whereas males learn to express emotional discomfort with externalizing problems such as substance abuse and antisocial behavior. Another consequence of gendered emotional socialization is that males and females learn to manage (i.e., inhibit, suppress, and/or transform) their "deviant" feelings and expressions when they depart from culturally based emotion norms. In short, gender differences in rates of internalizing and externalizing emotional problems in the U.S. may be micro—level reflections of our larger (i.e., macro—level) emotion culture.

Indirect support for this hypothesis is evident in Nath's and my study of gender and emotion, which shows that women report sadness more often than men even when sociodemographic and status differences between men and women are held constant (Simon & Nath, 2004). In another study, I found that men and women respond to the stress of marital loss (i.e., including both divorce and widowhood)

with gender-typical emotional problems (Simon, 2002). Indirect support for these ideas is evident in other research as well (see Aneshensel et al. [1991]; Rosenfield et al. [2000; 2006]; and Umberson et al. [1992] but not Umberson et al. [1996]). However, while this theoretical framework is promising for understanding *why* men and women express emotional distress in different ways, future research on this topic should directly assess men's and women's *beliefs* about culturally appropriate emotional experience and expression for males and females as well as the degree to which they manage their "deviant" feelings and expressions.

It is important to point out that the theoretical perspective about gendered responses to stress advanced above compliments Rosenfield's (1999; Rosenfield et al., 2000, 2006) important work on this topic. Rosenfield posits that gender differences in the manifestation of emotional disorders reflect gender-differentiated self-structures, which are a by-product of gender role socialization. Drawing on prior theoretical work on gender differences in personality and the social self (Chodorow, 1978), she argues and finds that females have other-focused self-structures, which predispose them to manifest distress vis-à-vis internalizing emotional problems such as depression. In contrast, males have ego-focused self-structures, which predispose them to manifest distress vis-à-vis externalizing problems such as antisocial behavior and substance abuse. A potentially fruitful and exciting area for future work on this topic is the *interrelationships* among culture, gender, the self, and emotion.¹³

Race and Ethnicity

These same theoretical ideas about the role and significance of emotion cultures, emotion norms, and emotional socialization for understanding gender differences in the manifestation of emotional problems can also be used to shed light on a paradoxical finding in the literature on health disparities in the U.S. (briefly touched on earlier) that has long puzzled health scholars. That is, while African Americans are less likely to have psychiatric disorders and report the same (or lower) levels of emotional distress than their white counterparts, they experience more (and more severe) physical disorders and health problems than their white peers (Brown et al., 1999; Dohrenwend & Dohrenwend, 1969; Dresser & Badger, 1985; George & Lynch, 2003; Jackson, Williams, Torres, Sellers, & Brown, 1996; Kessler et al., 1994; Schulz, Israel, Williams, Torres, Becker, & James, 2000; Smaje, 2000; Turner & Gil, 2002; Williams & Collins, 1997; Williams & Harris-Reid, 1999; Williams & Collins, 1997; Williams & Harris-Reid, 1999). Scholars suggest that the lower rates of emotional problems among blacks are due to highly supportive extended families and social networks in the black community, which buffer the deleterious emotional effects of stress. Health researchers also argue that the higher rates of physical health problems among

¹³ See Rosaldo (1980, 1984), Kleinman (1986, Kleinman & Good 1985), Lutz (1988), Lutz and White (1986), Kondo (1990), Mago (1998), and Milton and Svasek (2005) as well as Marcus and Kitayama (1991) and Kitayama and Marcus (1994) for fascinating discussions of the implications of cultural differences in the social self (e.g., the implications of ego versus other-focused self-structures) for the experience, expression, and meaning of emotion.

blacks are a by-product of racism, discrimination, and social disadvantage, which affect their health directly as well as restrict their access to health care.

However, it is conceivable that black-white differences in rates of mental and physical health problems also reflect deeply embedded sub-cultural norms and beliefs about appropriate feelings and expressive behavior. For example, the experience and expression of negative emotions such as sadness, loneliness, hopelessness, anxiety, worry, fear, and possibly anger may be viewed as inappropriate in African American culture. To the extent that this is the case—and there is some reason to believe that it may be—black individuals may learn from childhood on through emotional socialization to avoid, suppress, and transform (i.e., manage) these non-normative negative feelings and expressions. Some indirect support for this notion is evident in Nath's and my study of emotion; for example, we found that blacks report negative emotions in general—and feelings of sadness, anxiety, and anger in particular—less frequently than whites even after sociodemographic and social status variables are held constant. Together, these patterns strongly suggest that the stressors to which black persons are exposed take their toll on their *physiological* rather than on their *emotional* health and well-being.

To the extent that African Americans respond to stressful social situations with physical rather than emotional problems, it is crucial that research on racial inequalities in stress and mental health also examine physical health problems. Future research on racial disparities in health should also directly assess individuals' beliefs about culturally appropriate and inappropriate emotional experiences and expressions as well as the extent to which they manage their "deviant" feelings and affective behavior when they depart from social norms. Research on ethnic (i.e., Hispanic, Asian, & Native American) variations in mental (and physical) health should be particularly sensitive to these possibilities as well.

Note that these empirical observations for both gender and race differences in mental health in the U.S. provide unequivocal support for Aneshensel's (1992; Aneshensel et al., 1991) proposition that the effects of stress are highly specific and depend on the social characteristics of the person, the type of stressor involved, and the particular health problem examined (also see Barrett [2003] and Simon [1998, 2002]). That men and women as well as black and white individuals manifest emotional upset with distinctly different types of health problems also highlights the need for stress researchers to sample the "universe of stress outcomes" and include multiple health (i.e., multiple mental and physical health) outcomes in research on social group differences in the consequences of social stress, as Aneshensel (1999) argued several years ago.

Socioeconomic Status

Finally, although research demonstrates that socioeconomic status differences in symptoms of emotional distress and psychiatric disorders in the U.S. are partially explained by socioeconomic status differences in exposure and vulnerability to acute and chronic stressors (Turner et al., 1995), social class differences in emotion culture, emotion norms, and emotional socialization may also contribute to this

relationship. I mentioned earlier that studies have long shown that all types of emotional problems (ranging from the mildest forms of emotional discomfort to the most severe forms of mental illness) are more common among persons with lower levels of education and family income and lower status occupations than those with higher levels of education and family income and higher status occupations (Dohrenwend & Dohrenwend, 1969; Faris & Dunham, 1939; Hollingshead & Redlich, 1958; Kessler, 1979; Kessler & Cleary, 1980; Link et al., 1993; Yu & Williams, 1999). However, while there is little doubt that members of disadvantaged social classes are more exposed to stressful situations and lack coping and social support resources with which to buffer the negative emotional impact of stressors (Pearlin & Schooler, 1978), it is reasonable to posit that they are also less likely to manage their emotions by suppressing their negative feelings and invoking more positive ones.

Although there has been no empirical research on this topic to my knowledge, Hochschild (1979, 1983, 1990) claims that there are social class differences in emotion cultures, emotion norms, and emotional socialization, which ultimately result in class differences in the use of emotion management. Extrapolating from Kohn's (1969) classic work on class differences in parental values and childhood socialization, Hochschild argues that persons with higher status occupations routinely manage their emotions in order to satisfy occupational requirements. Consequently, parents with these occupations value and put a greater emphasis than those with lower status occupations on emotional introspection and control and socialize their children to both attend to and manage their negative and non-normative feelings and expressions. To the extent that this argument is correct, long observed socioeconomic status differences in mental health may also reflect socioeconomic status differences in the *management* of negative emotions. While studies document class differences in coping resources such as mastery and self-esteem (Mirovsky & Ross, 2003; Pearlin & Schooler, 1978; Thoits, 1995b; Turner & Roszell, 1994), future research should examine socioeconomic status differences in the use of coping strategies—especially emotion-focused coping behaviors—in order to assess the accuracy of Hochschild's provocative ideas.¹⁴

¹⁴ In addition to gender, race, ethnic, and socioeconomic differences in emotional disturbance, epidemiological studies of mental health in the U.S. find that younger adults report higher levels of emotional distress including depression and anxiety than older persons (e.g., Mirovsky & Ross, 2003). Closely paralleling these findings, research on the social distribution of everyday emotions in the U.S. finds that younger adults report negative feelings such as sadness, anxiety, and anger more frequently than older adults (Schieman, 1999; Simon & Nath, 2004). Scholars attribute age differences in emotion and mental health to structural factors that are associated with the early adult life course—a stage of life when individuals are establishing themselves in jobs and marriage and raising children. However, it is equally possible that observed age differences in emotion and emotional distress reflect age-related norms about appropriate feeling and expressive behavior. Because the experience and expression of negative emotions may be less accepted for older than for younger persons in American culture, future research should examine whether age-based emotion norms exist and if there are age and/or cohort differences in individuals' beliefs about appropriate feeling and expressive behavior. Future research should also investigate whether older persons are more likely than younger people to manage their negative feelings and expressions.

In sum, theoretical developments in the sociology of emotion enhance our understanding of persistent group differences in mental health problems in the U.S. As such, insights, concepts, and theories about emotion open up promising new directions for future research on these important issues. In my opinion, a logical next step for research on gender, race, ethnic, and socioeconomic status variations in mental health is to elucidate the many complex linkages among cultural (and subcultural) norms and beliefs about appropriate feelings and expressions, the content of emotional socialization, the use of emotion management (by self and others) to regulate non-normative feelings, and the types of emotional (as well as physical) health problems members of different social groups typically experience and express. The integration of theory and research from the sociologies of mental health and emotion would go far towards broadening and deepening our collective knowledge about social group differences in mental and physical health problems as well as group differences in affective responses to a range of social situations.

Conclusions: The Complementarity of the Sociologies of Mental Health & Emotion

In the first part of this chapter, I drew on findings from decades of research on the sociology of mental health in order to shed light on unresolved theoretical, social and debates in the sociology of emotion regarding the social antecedents, issues regulation, and social distribution of emotion. However, in discussing these findings, I also took the opportunity to suggest some ways in which insights from the sociology of emotion could enhance research on the etiology of emotional distress, the role of coping and social support for reducing emotional problems, and the social epidemiology of emotional disturbance in the population. In the second part of the chapter, I turned my attention to theoretical developments in the sociology of emotion that can contribute to theory and research in the sociology of mental health with respect to our understanding of persistent group differences in the experience and expression of emotional (and physical) health problems. There are undoubtedly other points of overlap between the sociologies of mental health and emotion that would benefit from this type of integration and cross-fertilization. I conclude the chapter by briefly highlighting some broad themes I touched on regarding the complementarity of theory and research on mental health and emotion and point to some topics that would profit from greater integration of these separate, yet highly interrelated, areas of sociological inquiry.

Since symptoms scales that are employed in research on mental health include some of the same feelings that are of interest to emotions researchers, sociologists of emotion can use findings from this body of work to evaluate as well as refine and expand theories and concepts about feeling and emotion.

With respect to the *social antecedents of emotion*, sociologists of mental health have developed an elaborate typology of social situations that are responsible for

the development and persistence of emotional problems among individuals in the general population. Emotions scholars should draw on this useful typology in order to assess whether everyday negative feelings can be traced to undesirable life events and on-going strains, and if so, whether these events and social situations are stressful because they decrease people's status in social relationships or disconfirm their social identities as Kemper and Heise argue, respectively. At the same time, sociologists of mental health should make greater use of these and other theories about emotion in order to elaborate the *social psychological mechanisms* that underlie people's emotional reactions to acute and chronic stressors. This would enhance their understanding of *why* these social experiences are emotionally distressing.

With regard to the *social regulation of emotion*, sociologists of mental health have developed an exhaustive inventory of coping and social support resources and strategies that individuals use to control their own and others' distressing emotions. Emotions researchers should draw on this rich source of data in order to broaden their knowledge about the multitude of ways in which people manage their own and other people's negative feelings. By the same token, coping and social support researchers should follow Thoits' lead by utilizing theoretical insights from the sociology of emotion and examining group differences in the use of emotion management in the population. Mental health researchers should also make use of Hochschild's cultural theory about emotion and investigate both cultural and sub-cultural norms variations in norms and beliefs about appropriate and inappropriate feelings and expressive behavior.

Finally, in terms of the *social distribution of emotion*, sociologists of mental health have provided a wealth of information about sociodemographic and social status variations in emotional distress in the U.S. Emotions researchers should utilize this extraordinary body of work in order to evaluate a number of different theories, including both structural and cultural theories about emotion. On the other hand, epidemiologists should draw on these theories about emotion and examine a broader range of emotional outcomes—particularly symptoms of emotional well-being—so that they could determine whether the absence of symptoms of distress is equivalent to presence of symptoms of well-being as Bradburn claimed and found several decades ago. Sociologists of mental health should also make use of rich theoretical insights from the sociology of emotion—especially theories that highlight the importance of emotion cultures, emotion norms, and emotional socialization for influencing individuals' perceptions about appropriate and inappropriate feelings and expressive behavior—in order to better understand persistent group differences in the manifestation of emotional problems in the population.

Thus, at the same time that emotions researchers should draw on research from the sociology of mental health in order to evaluate, refine, and expand their concepts and theories, mental health researchers should take advantage of concepts, theories, and insights from the sociology of emotion in order to explicate the mechanisms that underlie the development of mental health problems in the U.S. and persistent group differences therein. In addition to including a broader range of health outcomes (including emotional well-being as well as physical health

problems and physical well-being), mental health research should include a broader range of social situations that people experience—particularly life affirming desirable events and on-going positive social situations. The inclusion of positive and negative social experiences as well as measures of emotional and physical health problems and well-being in their work would allow mental health and emotions researchers to more fully capture the multitude of ways in which social life and social experience affect the emotional lives and health of individuals.

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