The study of nonverbal behavior has captured the imagination and interest of researchers across a number of disciplines, including psychology, sociology, anthropology, ethology, and linguistics to name but a few. At least since Darwin’s 1872 publication of *The Expression of Emotion in Man and Animals* (see also Ekman 1998), the study of nonverbal behavior has been particularly central to researchers interested in emotion. Indeed, contemporary conceptualizations of emotion all include reference to nonverbal behaviors, particularly facial expressions, as integral to emotional responding, due not only to Darwin but also to the pioneering work of Tomkins, Izard, and Ekman in the 1960s and early 1970s.

However, it has only been in the last two decades that research on the nature of emotion and psychopathology has illuminated the important role that nonverbal behaviors play in a variety of disorders (for reviews see Berenbaum *et al.* 2003; Keltner & Kring 1998; Kring 2001). This is somewhat surprising given the ubiquity of emotion problems in different psychological disorders. Indeed, emotion disturbances figure prominently in many different forms of psychopathology, whether they are ‘excesses’ in emotion, ‘deficits’ in emotion, or the lack of coherence among emotional components. As illustrated in Table 8.1, many of the disorders found in the current *Diagnostic and Statistical Manual* (DSM-IV-TR; American Psychiatric Association 2000) include one or more symptoms reflecting an emotion disturbance.

Much of the progress towards understanding the nature of emotion disturbances in psychopathology has been aided by the use of methods pioneered by basic emotion researchers. Indeed, basic research on the components of emotional responding in nonclinical populations has proven useful and relevant for the study of emotional dysfunction in clinical populations. However, considerably less research has been conducted on understanding how nonverbal behaviors outside the context of emotion may be related to the symptoms, etiology, or course of different psychological disorders. In this chapter, we focus on the methods, complexities, and promises of studying emotional behavior in different forms of adult psychopathology. After first defining emotion, we next consider in some detail some of the special considerations associated with studying emotional behavior in psychological disorders.

**Nonverbal behavior and emotion**

Drawing from over a century of theory and research, there is fairly good consensus that emotions are adaptive and serve important functions. Broadly defined, emotions are
Table 8.1 Emotion-related symptoms in DSM–IV–TR

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Emotion-related symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia, schizoaffective, schizophreniform</td>
<td>Affective flattening, anhedonia</td>
</tr>
<tr>
<td>Major depressive episode</td>
<td>Depressed mood, anhedonia</td>
</tr>
<tr>
<td>Manic episode</td>
<td>Elevated, expansive, or irritable mood</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>Depressed mood</td>
</tr>
<tr>
<td>Hypomanic episode</td>
<td>Elevated, expansive, or irritable mood</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>Intense fear or discomfort</td>
</tr>
<tr>
<td>Agoraphobia</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Specific phobia, social phobia</td>
<td>Marked and persistent fear</td>
</tr>
<tr>
<td>Obsessive–compulsive disorder</td>
<td>Marked anxiety or distress</td>
</tr>
<tr>
<td>PTSD</td>
<td>Irritability, anger, physiological reactivity, distress, anhedonia, restricted range of affect</td>
</tr>
<tr>
<td>Acute stress disorder</td>
<td>Symptoms of anxiety or increased arousal</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>Excessive anxiety and worry, irritability</td>
</tr>
<tr>
<td>Hypochondriasis</td>
<td>Preoccupation with fears of having disease</td>
</tr>
<tr>
<td>Anorexia nervosa</td>
<td>Fear of gaining weight</td>
</tr>
<tr>
<td>Sleep terror disorder</td>
<td>Intense fear and signs of autonomic arousal</td>
</tr>
<tr>
<td>Pathological gambling</td>
<td>Irritability, dysphoric mood</td>
</tr>
<tr>
<td>Adjustment disorder</td>
<td>Marked distress</td>
</tr>
<tr>
<td>Paranoid personality disorder</td>
<td>Quick to react angrily</td>
</tr>
<tr>
<td>Schizoid personality disorder</td>
<td>Emotional coldness, detachment, flattened affectivity</td>
</tr>
<tr>
<td>Schizotypal personality disorder</td>
<td>Inappropriate or constricted affect, excessive social anxiety</td>
</tr>
<tr>
<td>Antisocial personality disorder</td>
<td>Lack of remorse, irritability</td>
</tr>
<tr>
<td>Borderline personality disorder</td>
<td>Affective instability due to marked reactivity of mood, inappropriate intense anger or difficulty controlling anger</td>
</tr>
<tr>
<td>Histrionic personality disorder</td>
<td>Rapidly shifting and shallow expressions of emotion</td>
</tr>
<tr>
<td>Narcissistic personality disorder</td>
<td>Lacks empathy</td>
</tr>
<tr>
<td>Avoidant personality disorder</td>
<td>Fear of criticism, disapproval, or rejection</td>
</tr>
<tr>
<td>Dependent personality disorder</td>
<td>Fear of being unable to care for self or being left alone</td>
</tr>
<tr>
<td>Alcohol intoxication</td>
<td>Mood lability</td>
</tr>
<tr>
<td>Alcohol withdrawal</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Amphetamine intoxication</td>
<td>Euphoria or affective blunting, anxiety, tension, anger</td>
</tr>
<tr>
<td>Amphetamine withdrawal</td>
<td>Dysphoric mood</td>
</tr>
<tr>
<td>Caffeine intoxication</td>
<td>Nervousness, excitement</td>
</tr>
<tr>
<td>Cannabis intoxication</td>
<td>Euphoria, anxiety</td>
</tr>
<tr>
<td>Cocaine intoxication</td>
<td>Euphoria or affective blunting, anxiety, tension, anger</td>
</tr>
<tr>
<td>Cocaine withdrawal</td>
<td>Dysphoric mood</td>
</tr>
<tr>
<td>Hallucinogen intoxication</td>
<td>Anxiety or depression</td>
</tr>
<tr>
<td>Inhalant intoxiciation</td>
<td>Belligerence, euphoria</td>
</tr>
<tr>
<td>Nicotine withdrawal</td>
<td>Dysphoric or depressed mood, irritability, frustration, anger, anxiety</td>
</tr>
<tr>
<td>Opioid intoxication</td>
<td>Euphoria followed by dysphoria</td>
</tr>
<tr>
<td>Opioid withdrawal</td>
<td>Dysphoric mood</td>
</tr>
<tr>
<td>Phencyclidine intoxication</td>
<td>Belligerence</td>
</tr>
<tr>
<td>Sedative etc. intoxication</td>
<td>Mood lability</td>
</tr>
<tr>
<td>Sedative etc. withdrawal</td>
<td>Anxiety</td>
</tr>
</tbody>
</table>
complex systems that developed through the course of human evolutionary history to prepare an organism to act in response to environmental stimuli and challenges. Furthermore, emotions are comprised of a number of components, including (but not limited to) behavioral or expressive, feeling or experiential, and physiological, that are typically coordinated within the individual. Indeed, the coordination of these components, under most circumstances, serves a number of important intra- and interpersonal functions (e.g., Ekman 1994; Frijda 1986; Keltner & Kring 1998; Lang et al. 1990; Levenson 1992), although across different contexts, these components may only be loosely connected (Russell et al. 2003).

In our view, advances in the understanding of emotion disturbances in psychopathology will be best advanced by adopting the conceptualizations, definitions, and methods for assessing emotion posited by basic emotion researchers. As we have argued elsewhere (Kring & Bachorowski 1999), the functions of emotion in persons with various psychopathological disorders are comparable to those for nondisordered individuals. In many different disorders, however, one or more components of emotional processing are impaired in some respect, thus interfering with the achievement of emotion-related functions. For example, schizophrenia patients’ absence of facial expressions may evoke negative responses from others (Krause et al. 1992) and have a number of other consequences for social relationships and interactions (Keltner & Kring 1998).

We submit, then, that the study of emotion in psychopathology does not require different methods than those used to study emotion in nonpathological populations. Indeed, the promise of translating basic emotion theory and methods into the study of emotion and psychopathology has been realized in many areas of research, as we review later in the chapter. Although similar methods for assessing emotion in psychological disorders can and should be used, researchers must nevertheless take into consideration issues and characteristics of particular patient populations that may render interpretations of emotional behavior difficult. For example, when studying patients with schizophrenia, researchers must be mindful of possible medication side-effects that may manifest themselves as emotional disturbances (Kring & Earnst 1999).

Special considerations in the study of emotion and psychopathology

Conducting research with psychopathological populations requires special consideration with respect to a number of issues, including sample issues, diagnosis, treatment or medication effects, illness course, and comorbidity. Full review of these issues is beyond the scope and topic of this chapter; for additional exposition on these important considerations we refer interested readers to the chapter by Sher and Trull (1996) in the Annual Review of Psychology. We nevertheless believe it is important to discuss these issues in brief as they have enormous bearing on study design and the interpretation of findings from studies assessing emotional behavior and psychopathology.

Sampling issues
In psychopathology research, true experiments cannot be conducted due to the fairly obvious fact that persons cannot be randomly assigned to have a psychological disorder.
such as schizophrenia. Instead, most psychopathology researchers employ convenience or nonprobability samples by, for example, including patients from a particular hospital or outpatient clinic or recruiting nonpatient controls by accepting volunteers from the community (Sher & Trull 1996). Recruiting patients for a research study is difficult, fraught with special ethical considerations, and labor intensive, and thus convenience samples are often the most feasible. However, this approach is not without problems as selection biases can affect the generalizability and interpretability of the findings.

An additional sampling issue of relevance is the use of clinical versus subclinical samples. Clinical samples are typically defined as individuals who meet diagnostic criteria for a particular disorder. Subclinical samples may comprise individuals at risk for a particular disorder or individuals who exhibit a number of symptoms of a disorder but do not meet the diagnostic criteria for that disorder. Studies using subclinical populations are also referred to as analogue studies. In many studies using subclinical populations, college students scoring high on a symptom measure are compared to college students who do not score high on the measure. For example, many studies have examined college students selected on the basis of scores on the Beck Depression Inventory (BDI; Beck et al. 1961). However, this inventory was not designed to diagnose depression, only to assess its severity in a clinically diagnosed group. Some evidence indicates that selecting subjects solely on the basis of elevated BDI scores does not yield a group of people who can serve as a good analogue for those with clinical depression (Coyne 1994). High scorers may not be clinically depressed (Santor & Coyne 2001). Further, Hammen (1980) found that high scorers declined markedly when retested just two to three weeks later. On the other hand, other evidence suggests that individuals who score high on symptoms measures and yet do not meet diagnostic criteria do not differ markedly from individuals who meet diagnostic criteria (Gotlib et al. 1995). Kendall et al. (1987) provided a set of guidelines for investigators to follow when using the BDI in order to maximize comparability between studies using individuals scoring high on the BDI and studies using individuals who meet diagnostic criteria for depression.

Researchers interested in schizophrenia have studied individuals believed to be at risk for developing schizophrenia, sometimes referred to as ‘psychosis prone’. In the 1970s, Loren and Jean Chapman developed self-report scales of characteristics believed to reflect the precursors for schizophrenia, including physical and social anhedonia, perceptual aberrations, and magical thinking (Chapman et al. 1976; Eckblad & Chapman 1983; Mishlove & Chapman 1985). These investigators conducted a longitudinal study of college students at the University of Wisconsin by following, for 10 years, over 500 students who scored high on these measures to ascertain how many students would go on to develop schizophrenia (Chapman et al. 1994). The results of the 10-year follow-up indicated that a number of the students exhibited psychiatric symptoms, though very few actually developed schizophrenia, leaving some to wonder whether this is a useful analogue for schizophrenia research. However, other follow-up studies have indicated that social anhedonia is a significant predictor of the later development of schizophrenia spectrum disorders (Kwapil 1998).

Trull and colleagues (e.g. Trull 1995; Trull et al. 1997) have studied emotional, cognitive, and interpersonal features of borderline personality disorder (BPD) among
nonclinical college students who were not seeking treatment for BPD but who none-
theless demonstrated a number of BPD features. Individuals with a high number of
BPD features reported greater trait-negative affect, hostility, anxiety, and depression,
and less trait-positive affect than control participants who had no BPD features. What is
unclear is whether these individuals with BPD features differ in important ways from
patients with the diagnosis of BPD.

Decisions about whether to use patients who meet diagnostic criteria for a particular
disorder versus individuals with a number of symptoms should be made on both
theoretical and empirical grounds. The current diagnostic systems are works in progress
and, thus, considering as valid only those studies that use patients meeting diagnostic
criteria would be a mistake. On the other hand, studies that define ‘patient’ groups by
identifying college students with a very small number of symptoms (e.g. a score of 7 on
the BDI) are not likely to advance our understanding of a particular disorder. What
needs to be done is work that integrates both clinical and nonclinical studies to broaden
our understanding of emotional features and disturbances associated with the various
psychological disorders.

Diagnostic issues

Choosing to study individuals who meet diagnostic criteria for a particular disorder still
leaves a number of decisions for the researcher. First, decisions about which diagnostic
system to adhere to must be considered. Most often, the American diagnostic system,
currently DSM-IV-TR (APA 2000) is used. However, international researchers often
follow the International Statistical Classification of Diseases and Related Health Prob-
lems (ICD-10; World Health Organization 1992). Although the two systems do not differ
tremendously, there are subtle differences, which may render comparison across studies
using the different diagnostic systems difficult. Furthermore, both of these diagnostic
systems have undergone a number of revisions over the past 30 years. For example,
depending upon the disorder of interest, it can be difficult to compare findings from
studies conducted in the 1970s (DSM-II), early 1980s (DSM-III), and today (DSM-IV).

Beyond decisions about the diagnostic system, procedures for assigning diagnoses
must be delineated. In some studies, diagnoses are obtained from reviewing patients’
records. This is problematic in that clinical practices for assigning diagnoses vary quite a
bit from hospital to hospital and clinic to clinic, with some diagnoses made following a
10-minute conversation with a patient, others made from prior patient records, and still
others made from a systematic interview and treatment team case conference. Given
this variability, the stability and reliability of diagnoses across such sites is likely quite
low. Most research studies use structured clinical interviews, such as the Structured
Clinical Interview for DSM-IV (SCID-IV; First et al. 1994). The advantages to using
such structured interviews are many. First, the questions and scoring system in the
interview are standardized so that differences between investigators are minimized.
Second, training materials are available to increase the likelihood that different inves-
tigators use the interviews in a similar fashion. Third, these interviews have been used
in a large number of studies of different psychological disorders and the reliability and
validity of the instruments have been well established.
So as not to unnecessarily reify the diagnostic criteria for particular disorders, some investigators choose to study a spectrum of disorders. For example, many studies of schizophrenia may include patients with schizophrenia, schizoaffective disorder, schizophreniform disorder, and delusional disorder. Those who study autism may include patients with Asperger’s Syndrome and perhaps other pervasive developmental disorders. Those interested in studying depression may include persons who meet criteria for major depressive disorder and dysthymia. The reasoning behind such an approach is that any one set of diagnostic criteria is a fallible indicator of what is undoubtedly a broader range of pathology. On the other hand, hypotheses about emotion and a particular disorder (e.g. schizophrenia) cannot be as unequivocally tested with a broad-spectrum sample.

To be sure, the diagnostic criteria are a ‘work in progress’ and will likely continue to change. However, the specificity of a particular emotion disturbance cannot be tested with a sample that cuts across many (similar) disorders. At the least, researchers should be clear when describing the sample used in a study. Furthermore, inclusion of sufficient numbers of patients in each diagnostic group in order to systematically test for any differences in the dependent variables of interest is ideal.

Treatment issues

When studying patient groups, information about current and past treatment must be gathered and taken into consideration. Interpretation of findings about emotion disturbances in psychopathology may vary depending upon treatment status. For example, if an emotion disturbance exacerbates when patients are no longer receiving treatment, one might conclude that the treatment was effective in resolving the emotion disturbance. By contrast, an emotion disturbance that persists regardless of treatment status, as is the case with diminished expressiveness in schizophrenia (Kring & Earnst 1999), suggests that the disturbance is a stable aspect of the disorder that may be relatively resistant to treatment. Finally, if an emotion disturbance remits when patients are withdrawn from treatment, particularly medication, the emotion disturbance is likely a medication side-effect.

Indeed, in some disorders such as schizophrenia, side-effects from medication may present like the emotional phenomena of interest. For example, one of the most common and troubling side-effects of neuroleptic medication is akinesia (Blanchard & Neale 1992; Carpenter et al. 1985; Marder et al. 1991; Sommers 1985; Van Putten & Marder 1987; Van Putten et al. 1980). Although clinical descriptions of akinesia vary, it is typically defined by characteristics that are virtually identical to descriptions of the schizophrenia symptom of affective flattening, including diminished facial expression, nonspontaneous speech, and few gestures. Thus, it is often difficult to determine whether the diminished expressiveness seen in some schizophrenia patients is a symptom of the disorder or a side-effect of the medication.

A number of strategies have been employed to assess medication effects on various performance measures. Perhaps the most common method has been to examine the correlation between equated medication dosage levels and the dependent variables of interest. Although this approach provides useful descriptive information about medi-
cation dosage, it does not take into account the differential effect of different types of medications (Blanchard & Neale 1992). A second common approach is to assess medication side-effects with clinical rating scales and then to include these scores as a covariate in statistical analyses to partial out the effects of side-effects on performance. However, as discussed below, some rating scales for medication side-effects contain items that are virtually identical to items on scales designed to assess the emotion disturbance. Thus, relying solely on clinical rating scales will provide an incomplete assessment.

In order to assess the effects of medication on emotional behavior, one of the most powerful designs is a within-subjects design (Blanchard & Neale 1992) referred to by Spohn and Strauss (1989) as a counterbalanced crossover design. In this design, the same patients are tested both on and off medication, with roughly half of the sample being off medication at the first testing and then retested while on medication, and the other half of the sample being on medication at the first testing and then retested while off medication. The within-subjects aspect of the design allows patients to serve as their own controls, and the counterbalancing aspect of the design controls for order effects. Although this is a powerful design to detect medication effects on a dependent variable of interest, withdrawing medication from patients for research purposes is no longer possible in many hospitals and clinics. Thus, many investigators will be unable to clearly assess what, if any, effects medications may have on emotion behavior and instead note this as a possible alternative account for the findings reported.

Testing patients receiving treatment (medication or psychotherapy) is not without advantages. Indeed, in many respects this is a more ecologically valid assessment of patients with a particular disorder given that a large number of individuals do indeed receive treatment.

Course of illness

In their seminal review of cognitive theories of depression, Barnett and Gotlib (1988) distinguished between the concepts of antecedents, concomitants, and consequences. Briefly, for a variable such as nonverbal behavior to be considered an antecedent of a psychological disorder, it must be shown to precede the onset of the disorder. Features that are observed during an episode of a psychological disorder may be more accurately construed as concomitants, and those features that persist after the episode has abated might be considered consequences.

To interpret findings regarding emotional behavior and different psychological disorders, it is necessary to review the evidence in the context of the temporal course of the disorder. Specifically, evidence showing that emotion disturbances precede the onset of a given disorder would support the role of an observed emotion disturbance as antecedent to the disorder and allows for a clearer claim about the causal status of that disturbance. A prospective, longitudinal study is the best design to determine whether or not emotional disturbances precede the onset of a disorder; however, few such studies have been conducted. Evidence that emotional disturbances are present only during an active symptomatic state suggests that the disturbances are better construed as concomitants. Indeed, most of the research on emotional disturbances in
psychopathology has employed cross-sectional designs that are ideally suited to evaluate whether particular emotional features can be construed as concomitants.

Finally, if the evidence indicates that emotion disturbances persist after symptomatic recovery or predate a relapse, the disturbances may be construed as consequences of the disorder. Prospective, longitudinal designs again are the best method for ascertaining whether emotional features can be considered to be a consequence of the disorder. Understanding where, in the course of a disorder, certain emotional features or disturbances appear has important implications for treatment development as well as for theories of etiology (for a review see Kring 2001).

Comorbidity

Comorbidity refers to co-occurrence of more than one disorder. This is very common across all disorders. For example, 50% or more of patients with schizophrenia also have a substance abuse disorder (Blanchard et al. 2000); anxiety and mood disorders exhibit a tremendous amount of comorbidity (Mineka et al. 1998). Given that comorbidity is so common, findings from studies that examine a particular disorder (e.g., depression) that is not comorbid with another disorder (e.g. generalized anxiety disorder) may not generalize well to the larger population of individuals with depression. For example, there is some evidence to indicate that nonverbal behaviors observed in comorbid anxiety and depression (e.g. distressed facial expressions, hostility, agitation) differ from observations of depression (Katz et al. 1993). On the other hand, if researchers are interested in isolating a specific emotion disturbance for depression, then the place to begin is with a sample of patients with depression only. Later studies could include patients with depression and anxiety to test the generalizability of the particular emotion disturbance.

Why study emotion in psychopathology?

Although it may seem obvious that the study of emotion in psychopathology is of critical importance, since emotion is so central to many different disorders (see Table 8.1), we submit that it is important to be clear about the goals of such research. For example, in our view, research on emotional behavior or other nonverbal behavior in psychopathology will not supplant current diagnostic assessments. In other words, we doubt that different psychological disorders can be diagnosed by nonverbal or emotional behavior ‘signatures’ independent of other measures.

Furthermore, it is unlikely that emotion clearly distinguishes different psychological disorders (see also Pansa–Henderson et al. 1982). For example, findings by Watson et al. (1988), indicating that heightened levels of negative affect (NA) could characterize both anxiety and depression, while lowered levels of positive affect (PA) uniquely characterized depression, suggest that emotion might serve as a means for distinguishing among psychological disorders. However, subsequent research has shown that other disorders, including schizophrenia and social phobia show the same pattern of heightened NA and lowered PA (e.g. Berenbaum & Fujita 1994; Blanchard et al. 1998; Wallace & Alden 1994), casting doubt on the specificity of this pattern to depression.
Nonetheless, we do believe that findings on emotion and psychopathology will be a useful augmentation to diagnostic assessments, and we concur with Berenbaum and colleagues (2003) that the development of a taxonomy of emotion disturbances in psychopathology may have much clinical utility. While we are less optimistic that such a taxonomy may provide greater predictive power than current diagnostic systems (as nonverbal behavior is not necessarily indicative of gross psychopathology), it can nevertheless highlight subtle dysfunctional processes.

Numerous descriptive studies on nonverbal behavior and psychopathology have been conducted over the last 40 years; however, there has been little cumulative benefit from these studies. As highlighted above, changes in diagnostic systems and practices makes comparison across studies from different diagnostic ‘eras’ difficult, if not impossible. However, descriptive studies have also failed to advance our knowledge of emotion disturbances in psychopathology due to the overly descriptive nature of the research. A typical study may begin with a small sample of patients (e.g. 7–10) and then try to identify variables (e.g. facial expression, vocal expression, gestures, eye contact) that distinguish these patients from a nonpatient control group. Many of these studies are conducted without advancing hypotheses about how or why groups may differ and without sufficient conceptual or theoretical underpinnings to constrain such hypotheses. Thus, the literature is replete with several mini-findings that neither advance our understanding of a particular disorder (with respect to symptoms, course, etiology, or treatment) nor advance our understanding of the ways in which emotion disturbances are manifest within a particular disorder or constellation of symptoms.

As noted above, it is important to discover where emotion disturbances are situated in the temporal course of a given disorder, and this is a laudable goal for research on emotion and psychological disorders. For example, finding particular emotion behaviors prior to the onset of an illness would suggest that these behaviors have the potential to be construed as a marker for the illness or a vulnerability indicator (Nuechterlein & Dawson 1984). Finding a constellation of emotion disturbances concomitant with an episode of a disorder points to the possibility that changes in this disturbance can be used as an indicator of treatment effectiveness. Addressing these questions requires prospective, longitudinal designs.

An additional goal for researchers interested in emotion and psychopathology might be to develop newer, more effective interventions. The theorizing of Marsha Linehan about the role of emotion regulation deficits in borderline personality disorder (BPD) led to the development of dialectical behavior therapy (DBT; Linehan, 1993) for this disorder. Theories posited by Linehan and others (Linehan 1987; Snyder & Pitt 1985; but see Farchaus–Stein 1996) have suggested that individuals with BPD have difficulty returning to an ‘emotional baseline’ following an emotional event. Furthermore, empirical evidence suggests that BPD patients report chronic and intense feelings of a number of negative emotions, including anger, hostility, depression, loneliness, and anxiety (e.g. Coid 1993; Farchaus–Stein 1996; Gunderson et al. 1975; Gunderson & Phillips 1991; Kruegelbach et al. 1993; Soloff 1981; Soloff & Ulrich 1981; Snyder & Pitt 1985).

Portions of DBT involve training patients in a number of emotion regulation skills, including reorientating of attention, changing facial and body language, perspective
taking, inhibition of mood-dependent actions, and experiencing emotion without escalating or blunting the feelings (Linehan 1993; Linehan & Schmidt 1995; Robins et al. 2001). Although there are several studies showing the effectiveness of this intervention, little work has yet been conducted to confirm the emotion mechanisms believed to be central to the disorder. The development of DBT followed from theory, and the attendant empirical work to support the hypothesized emotion regulation deficits is now being conducted (e.g. Lynch et al. 2001).

An alternative approach would be to build an intervention based on accumulated findings about a particular emotional behavior disturbance in a disorder. For example, accumulated evidence shows that schizophrenia patients are less emotionally expressive than nonpatients (see Kring 1999 for a review). Certainly, expressive behavior is an important part of socially skilled behavior. However, recent evidence suggests that the emotional deficits in schizophrenia are distinct from social skills deficits (Salem & Kring 1999), and thus interventions aimed at improving social skills may not necessarily change expressive behavior. These interventions could be strengthened by including components that specifically target emotional disturbances (e.g. expressing emotion at the right time in the appropriate contexts; interpreting emotions in others) as well as the performance of socially skilled behavior.

Approaches to studying emotion and nonverbal behavior in psychopathology

A number of different approaches to studying emotion and nonverbal behavior in psychopathology have been used. Some of these methods are more specific to psychopathology (e.g. symptom rating scales), whereas others are commonly used in other areas of research (e.g. facial expression coding systems such as FACS). This diversity of methods is both a blessing and a curse. Some of the methods are designed with the complexities associated with different disorders in mind. However, the sheer number of different methods throughout the literature makes comparisons across studies quite difficult. In this section, we present a cross-section of these methods, highlighting the strength and weaknesses of each along the way.

Symptom rating scales

Symptom rating scales are not typically derived to assess nonverbal behavior or emotion. However, to the extent that a particular disorder involves emotional or nonverbal behavior symptoms, they will be included in these rating scales. Most generally, symptom rating scales are completed following an interview with a patient. These interviews typically focus on the signs and symptoms of a particular illness. Table 8.2 includes a description of some commonly used clinical rating scales for adult psychopathology. These interviews were designed to assess specific symptoms and their severity and as an aid to diagnosis. Individual subscales may contain items relevant to emotion or nonverbal behavior, and other research suggests that these measures are related to other indices of emotion. For example, Kring et al. (1994a) found that the affective flattening subscale of the Schedule for the Assessment of Negative Symptoms
(SANS; Andreasen 1984) was related to coded facial expressions of positive and negative emotion and an acoustic assessment of vocal prosody.

Although these interviews and rating scales are quite effective in assessing specific symptoms of a disorder, they are not a particularly effective means for assessing emotion and nonverbal behavior. First, the behavioral sample upon which they are based may not be representative because the ratings are typically made at one particular time, usually while the patient is in the hospital. Second, the format of these interviews also relies on a certain degree of clinical skill that may systematically fail to elicit emotional material, and thus may not provide an opportunity for patients to express a wide range of emotions. Third, the items on most rating scales do not differentiate between reduced expression of positive versus negative emotions but, rather, assess overall reduced expressiveness, therefore resulting in data that are uninformative with respect to particular emotions. Finally, most uses of the rating scales require a tabulation of a total score rather than specific subscale scores. Thus, knowing the overall total on the BPRS is informative with respect to overall symptomatology, but it does not provide any specific information about emotional symptoms.

A special type of clinical rating scale often of interest to researchers studying the emotional features of schizophrenia is one that assesses medication side-effects. As noted above, akinesia can appear virtually identical to flat affect. Unfortunately, the items on clinical rating scales used to rate akinesia are often the same items used to
assess flat affect. This suggests the need for a more comprehensive and fine-grained behavioral assessment of expressive behavior and emotional responding that goes beyond rating scales for symptoms and medication side-effects.

Self-report measures of symptoms or diagnosis
Many symptom self-report measures have been developed. Review of these measures far exceeds the scope of this chapter. In almost all cases, these measures were not developed to assess emotion or nonverbal behavior associated with a particular disorder. Rather, they were developed to assess symptoms of disorders. Like the clinical interviews discussed above, these measures include items related to emotion only if emotion-related symptoms are part of the disorder. Taken alone, then, these measures are not a good measure of emotion in psychopathology. Taking out emotion-relevant items to form a new ‘subscale’ violates the integrity of the measure and is therefore not recommended. These measures may be used to augment other measures of emotion and psychopathology but, like clinical interviews, the primary purpose of these measures is to provide information about diagnosis, symptom severity, or both.

Observational ratings
Other methods for assessing emotion and nonverbal behavior include direct observational ratings. Most often, these studies have been conducted with patients who are inpatients. For example, Brown et al. (1979) observed and rated overt changes in facial expression associated with pleasurable activities that were exhibited by six schizophrenia and five depressed inpatients; schizophrenia patients exhibited significantly more such changes than did depressed patients.

The Autism Diagnostic Observation Schedule—Generic (ADOS–G; Lord et al. 2000) is a combination of clinical interview/rating scale and observational method. The generic version of this measure was developed for use with a broader age range of individuals, including adults, following the success of the ADOS (Lord et al. 1989; Lord et al. 1999) in diagnosing autism in children ranging from 5–12 years old. The ADOS–G involves a number of activities and interactions that allow an examiner to assess social–emotional and other disrupted behaviors, as well as language capabilities. Activities include conversational interactions/interviews, examining cartoons, creating a story, describing a picture, and telling a story from a book. Some of the emotional behaviors assessed by the ADOS–G include unusual eye contact, whether or not facial expressions are directed towards others, empathetic or emotional gestures, empathy/comments on others’ emotions, shared enjoyment, mannerisms, negative behaviors, and anxiety. Like most clinical interviews, a good bit of training is necessary in order to administer the measure accurately and competently.

Other descriptive, observational approaches come from the ethological psychiatry tradition (Troisi 1999). From this perspective, nonverbal behaviors are observed, catalogued, and conceptualized from an evolutionary standpoint (e.g. Pederson et. al 1988). Nonverbal behaviors are not necessarily presumed to reflect emotion, consistent with other ethological approaches to nonverbal behavior (e.g. Birdwhistell 1970;
Mitchell & Thompson 1986; Smith 1985). These studies typically include very small numbers of patients and describe a very large number of behaviors, most usually during an inpatient hospital stay.

One goal of the ethological psychiatry approach is to describe the behavior of the ‘typical patient’. This implies that a psychological disorder can be identified by a particular nonverbal behavior ‘signature’. However, this assumption does not leave much room for individual variation—yet individual differences are widespread in both patient and nonpatient populations. Additionally, since most of these studies include such a small sample of patients (due largely to the labor-intensive work associated with observing hundreds of behaviors), generalizations to larger groups of patients cannot be clearly made.

Findings from this approach have suggested that certain nonverbal behaviors may change over the course of a hospital stay for patients with depression and schizophrenia. For example, Pederson et al. (1988) observed and recorded the presence or absence of 142 different behaviors exhibited by five hospitalized depressed patients. Observations were conducted for four hours each day during the entire hospital stay (ranging from 4 to 11 weeks). Analyses were concerned with identifying behaviors that changed from the first to last week of hospitalization and how these behaviors correlated with symptom ratings of depression. Patients who improved the most during their hospital stay tended to display greater activity towards the end of the stay (e.g. more communication, getting out of bed, greater eye contact). Yet, there were widespread individual differences even among just five patients.

Similar findings were reported by Fossi et al. (1984) who observed 110 different behaviors among 29 hospitalized depressed patients. After treatment, patients exhibited greater eye contact, more exploration in the environment, and more frequent facial expressions of emotion. Towards the end of the hospital stay, patients spent less time in their rooms and more time in common areas compared with the early part of the hospital stay. Schelde (1998) also found behavior changes in 11 patients with depression following an inpatient stay of between 3 and 15 weeks. Specifically, patients showed less withdrawal, nonspecific gaze, more mouth movements, more social interest, more smiles, and more verbal social behavior. Other findings show that depressed individuals exhibited more excitement, gestures, and head movement following recovery (Bos et al. 2002; Geerts & Bouhys 1998; Geerts et al. 1996).

Although findings such as these may be informative with respect to generating hypotheses for future studies about nonverbal behavior and depression, they are limited by numerous methodological issues, including:

- small sample sizes;
- variations in treatment;
- insufficient information about patients’ symptoms;
- lack of a control group.

More recent ethological studies have attempted to predict prognosis and treatment response (Troisi 1999). The Ethological Coding System for Interviews (ECSI) was developed to rate behaviors occurring in the context of a clinical interview. Thirty-seven different behaviors are rated using this system, and seven subscales are then
created: affiliation (e.g. smile, eye raise); submission (e.g. nod, lips in and pressed together); prosocial (affiliation and submission combined); flight (e.g. look away, look down, shut eyes); assertion (e.g. lean forward, head shake, thrust, frown); displacement (e.g. scratch, fumble, yawn, hands on face); and relaxation (e.g. relax, settle, laugh, arms across chest). In a sample of 18 male schizophreniform patients, Troisi et al. (1991) found that patients with a poor prognosis had less eye contact and more eye closures during an interview than patients with a good prognosis. Troisi et al. (1998) found that 28 drug-free, male schizophrenia patients showed less prosocial behavior and displacement and fewer gestures than 12 healthy controls or 13 medical students. Troisi et al. (1989) found that 14 depressed individuals who responded to medication (amitriptyline) showed more affiliation and assertion. These findings, though based on small sample sizes, support the use of this system for assessing nonverbal behaviors in the context of an interview, but not emotional behavior per se.

Laboratory paradigms and coding systems

Borrowing directly from the basic emotion literature, researchers have used a number of laboratory paradigms to elicit emotion in persons with different psychological disorders. These studies typically involve presenting patients with emotionally evocative stimuli (e.g. film clips, pictures, slides, odors) and asking them to rate their experience of emotion following the presentation. Facial expressions are often videotaped and later coded and, in some cases, psychophysiological measures are also employed. The advantages to this approach are many. First, stimuli often have been used in a number of studies, thus bolstering confidence in their emotion-eliciting capabilities. Furthermore, a number of studies have also used these stimuli with patient populations, further confirming their applicability to psychopathology research. Second, these studies are conducted in laboratory settings where a number of extraneous variables can be brought under experimental control, thus making interpretation of findings more clear. Third, these studies typically involve assessments of multiple components of emotion allowing for a more comprehensive understanding of emotion function (or dysfunction) in a particular patient group. Fourth, methods used to assess emotion behaviors, such as facial expression, are often well-validated systems used in a number of studies.

This approach is not without limitations, however. For example, the ecological validity is less than ideal. Knowing how patients respond to emotionally evocative films clips does not necessarily translate into knowing how patients respond to emotional events in daily life. In addition, certain emotions (e.g. anger) are more difficult to elicit in a laboratory context than others (e.g. happiness), limiting the range of emotions that can be studied. Finally, these studies often examine emotional behavior in the individual, without regard to contextual influences (e.g. social interaction).

A range of emotionally evocative stimuli have been used in laboratory studies of emotion and psychopathology. While all laboratory inductions of emotion are somewhat artificial in nature, viewing film clips is a relatively common activity for most people. This method is also not reliant on subjects’ ability to recall past experiences. Slides or still photographs present momentary emotional scenes, whereas film clips
present a more realistic context in which emotional experiences typically develop over time. Additionally, this procedure has been used successfully with different patient populations (e.g. Berenbaum & Oltmanns 1992; Kring & Earnst 1999; Kring et al. 1993; Kring & Neale 1996; Litz et al. 2000; Rottenberg et al. 2002). Finally, film clips ensure that the nature of emotional stimuli is consistent across all subjects. Other widely used stimuli in laboratory research include pictures of facial expression (e.g. Kring et al. 1999; Sloan et al. 2002) and emotionally evocative slides (e.g. Allen et al. 1999; Sloan et al. 1997, 2001).

Studies that videotape facial expressions for later coding have used a variety of coding systems, such as the Facial Action Coding System (FACS: Ekman & Friesen 1978; Ekman et al. 2002) and the Facial Expression Coding System (FACES: Kring & Sloan 1992). These systems have been developed with nonpatient populations and used in several studies of basic emotion processes in both patient and nonpatient populations. Other studies have created a coding scheme for a particular study and not for widespread use by other investigators. Decisions about which method of measurement to adopt should be driven by both theoretical and practical considerations.

Widely considered the standard in observational coding systems, FACS was designed to provide a comprehensive assessment of all visible facial muscle movements without explicitly making reference to the meaning of those movements. FACS coders are trained to identify 44 anatomically distinct muscle movements (e.g. lip corner puller), labeled action units (AUs), but they are not asked to make inferences about underlying emotional state (e.g. happy expression). Directions for identifying particular AUs believed to be signs associated with emotional expressions is provided with FACS. FACS is theoretically aligned with a discrete emotions perspective, whereby a set of biologically based and functionally significant basic emotions are postulated (e.g. Ekman 1992). The emphasis, therefore, is on identifying AUs that are relevant to seven basic emotions: fear, anger, disgust, happiness, sadness, surprise, and contempt.

Kring and Sloan (1992) developed FACES as a systematic method for rating dimensional expressivity. Rather than assessing discrete emotions associated with specific muscle movements, FACES coders rate the changes in facial musculature that are associated with valence and intensity. We adopted the assumption that coders will be culturally familiar with facial expressions and, thus, will be able to identify facial muscle changes of positive and negative valence. FACES has been used in studies of emotional responding in various patient populations (e.g. Aghavli et al. 2003; Kring et al. 1993; Kring & Neale 1996; Wagner et al. 2003) and college students (e.g. Kring et al. 1994b; Kring & Gordon 1998).

Other laboratory approaches to assessing nonverbal behavior in psychopathology include the role play test (RPT: e.g. Bellack et al. 1990b). Patients are given a number of different scenarios (e.g. someone asks to borrow money and you were planning to spend the money on something for yourself) and are asked to act out how they would respond in the scenario. These role plays are videotaped and later rated for verbal and nonverbal behaviors. The impetus for the development of the RPT was to develop a system upon which objective assessment of social competence among psychiatric patients could be based. In the RPT, the videos are rated for gaze appropriateness,
speech duration, meshing (smooth conversation), and affect. Other RPTs include the Assessment of Interpersonal Problem Solving Skills (AIPSS; Donahoe et al. 1990).

Approaches in action: emotion and psychopathology

In this section, we review selected findings on emotional behavior in adult psychopathology. This review is intended to highlight the promise of adopting basic emotion paradigms to the study of emotion in psychopathology, despite the numerous complexities associated with psychopathology research.

Schizophrenia

A number of investigators have used methods for eliciting emotion and measuring emotion behavior that were developed by researchers studying basic emotion in order to investigate emotional responding among patients with schizophrenia. These studies, most of which were conducted in the last 12 years, have yielded a consistent and well-replicated set of findings.

Schizophrenia patients are less expressive (both facially and vocally) than nonpatients in response to a variety of contexts and stimuli, including emotionally evocative films (Berenbaum & Oltmanns 1992; Kring & Earnst 1999; Kring & Neale 1996; Kring et al. 1993; Mattes et al. 1995), cartoons (Dworkin et al. 1996), and social interactions (Borod et al. 1989; Krause et al. 1989; Martin et al. 1990; Kring et al. 1994a; Mattes et al. 1995). In addition, schizophrenia patients’ pattern of facial and vocal expression have been distinguished from other patient groups with symptoms that bear resemblance to the vect, including depression, Parkinson’s disease, and patients with right hemisphere brain damage (Borod et al. 1989; Levin et al. 1985; Martin et al. 1990; Berenbaum & Oltmanns 1992). Despite their diminished expressive behavior, schizophrenia patients reported experiencing similar and, in some cases, greater amounts of emotion compared to nonpatients (Berenbaum & Oltmanns 1992; Earnst & Kring 1999; Kring & Earnst 1999; Kring & Neale 1996; Salem & Kring 1999).

It is important to point out that we, and others, have found this same pattern both when patients were on medication (Berenbaum & Oltmanns 1992) and when they were off medication (Kring et al. 1993; Kring & Neale 1996; Kring & Earnst 1999). Moreover, we have found that both facial expression and subjective experience are remarkably stable across time and medication status (Kring & Earnst 1999). Additional evidence shows that schizophrenia patients exhibit very subtle, microexpressive displays in a manner consistent with the valence of the stimuli (Mattes et al. 1995; Earnst et al. 1996; Kring et al. 1999; Kring & Earnst 2003). For example, we have shown that in response to positive stimuli, schizophrenia patients exhibit more zygomatic (cheek) muscle activity, which is typically associated with positive emotion, than corrugator (brow) muscle activity, which is typically associated with negative emotion. By contrast, in response to negative stimuli, patients exhibit more corrugator activity than zygomatic activity (Kring & Earnst 2003).

Although schizophrenia patients may exhibit subtle facial expressions, these displays are not observable to others, and this relative inexpression has a number of
interpersonal consequences. For example, spouses of schizophrenia patients with negative symptoms, including flat affect, reported greater marital dissatisfaction (Hooley et al. 1987). Healthy individuals reported experiencing more fear and sadness and were themselves less expressive when they interacted with a schizophrenia patient than when they interacted with another healthy individual (Krause et al. 1992). Using symptom rating scales to measure diminished expressivity, Bellack et al. (1990a) found that patients who were the least expressive had poorer interpersonal relationships and poorer adjustment at home and in other social domains. Without the benefit of overt signs of emotion, others may misinterpret the ongoing emotional state of a patient with schizophrenia. Moreover, there is some evidence indicating that schizophrenia patients may not be aware of how unexpressive they are (Kring 1991). Thus, patients may not understand others’ reactions in ongoing interactions, and they may not take alternate measures to make their emotional state known.

There is some evidence to suggest that schizophrenia patients may display fewer facial expressions (particularly positive expressions) prior to the onset of the illness. For example, Walker and colleagues (1993) obtained home movies of adults with schizophrenia that were made before these adults developed schizophrenia. They coded facial expressions from the home movies of pre-schizophrenic boys and girls and found that girls displayed fewer joy expressions and that both boys and girls displayed more negative facial expressions compared to their healthy siblings. Findings from prospective, high-risk studies have reported similar findings. High-risk studies identify a group of children at risk for developing schizophrenia (typically defined as having a biological parent with schizophrenia) and then follow them from childhood through the period of risk (Neale & Oltmanns 1980). Teacher ratings from the Copenhagen High-Risk Study indicated that boys and girls who were later diagnosed with schizophrenia were more emotionally labile, socially withdrawn, socially anxious, and relatively unexpressive than children who did not develop schizophrenia (Olin et al. 1995; Olin & Mednick 1996). Findings from the New York High-Risk Project indicated that flat affect was greater among adolescents at risk for developing schizophrenia than adolescents at risk for developing affective disorders (Dworkin et al. 1991).

**Mood disorders**

Accumulated evidence indicates that individuals with major depressive disorder (hereafter referred to as depression) exhibit dampened facial, vocal, and gestural expressive behavior (Berenbaum & Oltmanns 1992; Ekman & Friesen 1974; Gotlib & Robinson 1982; Hargreaves et al. 1965; Jones & Pansa 1979; Kaplan et al. 1999; Murray & Arnott 1993; Scherer 1986; Schwartz et al. 1976; Ulrich & Harms 1985; Waxer 1974). In addition, dampened expressive behavior among individuals with depression may be specific to positive expressions, though this needs additional study. For example, Berenbaum and Oltmanns (1992) found that depressed individuals showed fewer facial expressions in response to positive stimuli (but not to negative stimuli) than nonpatients and schizophrenic patients with flat affect.

In other studies, researchers examining emotion and other nonverbal behavior in social interactions found that currently depressed individuals exhibited less eye contact.
than recovered depressed individuals (e.g. Hinchliffe et al. 1971; Wexer 1974, 1976) or nonpatients (Troisi & Moles 1999) and that greater eye contact and gaze were associated with a reduction in symptoms over the course of inpatient treatment (Ellgring 1986). Other findings suggest that depressed individuals exhibit less eye contact in more interactions that are unobtrusively observed than in laboratory paradigms (Segrin 1992). In a review of social functioning and depression, Feldman and Gotlib (1993) noted a number of studies that found depressed individuals to exhibit little eye contact, few smiles, and monotonous speech in interactions with unfamiliar others, yet exhibited more negative emotions and disruptions with spouses.

Expressive vocal deficits have also been studied in depression. Broadly, the speech of depressed individuals has been qualitatively described as flat, dull, and slow in tempo (Buck 1984; Hargreaves et al. 1965; Levin et al. 1985; Murray & Arnott 1993; Scherer 1986). Acoustic analyses, such as those derived through the analysis of digitized waveform representations of speech, have also proven useful in distinguishing between the speech of depressed and nondepressed individuals. For example, Bettes (1988) reported that mothers with self-reported symptoms of depression produced infant-directed speech with narrower pitch contours than were observed in the infant-directed speech of control mothers. Similarly, Kaplan et al. (1999) also noted different patterns of pitch modulation and variability in the infant-directed speech of mothers with symptoms of depression. Other researchers have shown that depressed individuals exhibit less affection, fewer gazes, flat affect, and less playing with their infants (reviewed in Feldman & Gotlib 1993).

Even fewer researchers have examined emotional behavior in bipolar disorder. Simoneau and Miklowitz (1991) developed a coding system for nonverbal behaviors exhibited during family interactions called the Nonverbal Interactional Coding System (NICS). Using this system, bipolar patients have been found to exhibit greater affiliative behaviors (e.g. gestures, leaning) yet similar amounts of distancing behaviors (e.g. looking away, leaning away) in interactions with parents than schizophrenia patients (Simoneau et al. 1996). Bipolar patients from families rated low in expressed emotion (EE) displayed more positive nonverbal behaviors in a family interaction than bipolar patients from families rated high in EE (Simoneau et al. 1998). There is also some evidence to suggest that an empirically supported psychosocial intervention for bipolar disorder, family focused treatment (FFT: Miklowitz & Goldstein 1990; Miklowitz et al. 2003), has an effect on emotional behavior in bipolar patients. Compared to pre-treatment, patients exhibited more positive nonverbal behavior after receiving FFT (Simoneau et al. 1999).

**Anxiety disorders**

Surprisingly, little is known about emotional behavior among patients with anxiety disorders, with the most research on nonverbal behavior and anxiety being conducted with social phobia. Social phobia is characterized by anxiety, fear, and avoidance of social situations, performance, and evaluations. Indeed, individuals with social phobia do not experience such anxiety when alone, but rather experience extreme anxiety when confronted with a social situation that involves interaction or presumed evaluation (Barlow 2002).
Findings from one study suggest that individuals with social phobia display nonverbal behaviors characteristic of anxiety. Marcus and Wilson (1996) studied social anxiety among college women during an observed speaking task. Observers’ ratings of anxiety were significantly related to speakers’ reports of anxiety, even though speakers rated themselves as more anxious than they were rated by observers. These findings indirectly suggest that social anxiety is comprised of relatively easily recognizable nonverbal behaviors and cues. Fydrich et al. (1998) developed the Social Performance Rating Scale (SPRS) to assess verbal and nonverbal behaviors exhibited by social phobia patients during a role play test. Items rated include voice quality, gaze, discomfort, and talk time, and these items distinguished socially phobic adults from a non-patient control group. Wallace and Alden (1995) found that individuals with social phobia exhibited fewer positive nonverbal behaviors and less warmth and interest during a dyadic social interaction. Socially phobic individuals also were rated as more visibly anxious than their non-anxious counterparts.

Conclusions

Given the central role emotion plays in several psychological disorders, the assessment of nonverbal and emotion behaviors can be of tremendous benefit to furthering our understanding of the symptoms, course, and treatment of psychopathology. We have suggested that the methods developed to study emotion in nonpatient populations are extremely useful for psychopathology research. Indeed, as briefly reviewed here, adopting methods from basic emotion research has allowed investigators to study multiple components of emotional response in emotionally evocative situations and has revealed a number of important findings about emotional behavior in psychopathology.

Laboratory-based measures of emotional responding can provide important information that is not easily accessed with clinical rating scales. For example, ratings of flat affect might be misinterpreted to mean that a schizophrenia patient is without feeling. Indeed, studies that rely solely on clinical rating scales that typically assess only one component of emotion may fail to adequately capture the essence of the emotional disturbance in schizophrenia, which appears to be the lack of coordinated engagement of emotion response components. Although the experimental control offered by a laboratory manipulation of emotion answers important questions, its generalizability is limited. Results from these laboratory studies can suggest a number of hypotheses that can then be tested in a more ecologically valid (but less well-controlled) setting. For example, examining emotional response tendencies in contexts such as social interaction with family members is a direction that deserves further empirical attention. Thus, a combination of both laboratory and naturalistic research, augmented with information from self-report and clinical rating scales, will likely yield the most complete picture of emotion disturbances in psychopathology.

There is no question that emotional disturbances figure prominently in psychopathology. Additional research is needed, however, to more fully illuminate the manner in which emotional behaviors may contribute to the onset, maintenance, and long-term
consequences of the disorders. Research that encompasses a wide variety of methods and multiple levels of analysis is the most promising approach not only to understanding emotion dysfunction, but also to developing effective interventions.

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Author Queries

[q1] There are no details for Wallace & Alden 1995 in the reference list, but there are for Wallace & Alden 1996. Is this one and the same reference? If so, which date is correct? If not, add details to reference list.