ically, all specifically idiosyncratic body behavior lies outside the field of kinesics, whether such behavior gains its peculiar cast from organic sources or from some special conditioning experience on the part of the actor or viewer. Yet it is essential to the methodology of kinesics, as it is for linguistics, that the behavior of any participant in an interaction situation be described as idiosyncratic only after the patterned aspects of the behavior have been exhaustively described. That is, in the process of classification and testing, individuality is assigned *after* not *before* the fact of data exhaustion. Our theoretical framework provides us with an approach to the problems of allocating data to prekinesic or to macrokinesic levels, but only when cross-cultural research provides us with clear indications of symptomatic activity concurrent with specific organic malfunction can we be secure in our assessment of particular pieces of behavior.

While anthropologists have long been aware of differing cultural emphases on disease or accident, the literature is exceedingly thin with regard to the specific variations in symptom presentation. Discussion of this problem with physicians whose practices are limited to the ethnic variations of an American city has convinced me that practitioners are aware of the difficulties involved in treating symptoms expressed by various groups as though there were a common and universal symptom structure for a given disease. This point was repeatedly stressed by M.D.'s whose practice included the range of variation provided by a Santa Fe or an Albuquerque hospital. Yet to my knowledge the data remains essentially impressionistic. Perhaps as the World Health Organization expands its research area, specific and extensive attention will be given to the cross-cultural examination of the social structuring of symptoms. Such data as would be supplied by these studies—properly organized—should help us to be more explicit about the separation of prekinesic and kinesic behavior.

My own convictions in this area derive from experience gained while doing research on the social structure of two adjacent but differing subcultures in central Kentucky. Not only did the "Bluegrass" and "Hill" Kentuckians differ in their attitudes toward disease in general, but their choices of favorite ailments varied as systematically as did other aspects of their social organization. This research was done prior even to the preliminary systematization of kinesics, yet we were aware of the fact that there were styles of symptom presentation in both verbal and kinesic statements of illness which were sufficiently different in the two areas as to lead to misunderstanding between them. The discussion to follow is based on insights gained during this community research project, measured against the material gathered by a number of investigators in the cross-cultural sphere, and reinterpreted through the recent formalization of communication research.

Although Dry Ridge was only about 15 miles into the hills from the Bluegrass community Green Valley, the health set of this area is markedly different from that characteristic of the valley. As a culture, more rigorously individualistic and puritanical than Green Valley, sickness was patterned in Dry Ridge into "nonreference to health" and "critically ill." Ideally, any variation between these two states is to be ignored or, at least, should remain a private matter. Ideally one is *forced* to go to a doctor, take medicine, or go to bed. The kinesic message that one is critically ill (although conscious and not yet bed-ridden) is best covered by the gestural reference, "stiff upper lip." This includes retraction of the scalp, tightening the skin of the forehead (with a significant reduction of brow markers), reduction of smiling, carrying the torso hyper-erect, reduction of velocity in hand and arm movement, increased precision in gross movement (decreased overkick—anterior and posterior—while walking) and increased "foot-planting" (both feet—heel and ball—on floor while standing or sitting). If this does not elicit response from responsible kindred, this general quality is sporadically interrupted by "sag" behavior of about 2 to 5 seconds' duration followed by "pulling together" behavior of about 2 to 4 seconds' duration. The sag and pull-together should not take place very often or the quality shifts and the behavior is reacted to as malingering or as an infantile appeal. I have never, in over a year of watching this behavior, seen the sag and pull-together used by males more than once in 15 minutes except by the very young and the very old. Females, on the other hand, sag and pull-together more frequently—several as often as two or three times in 5 minutes. This statement of variation is probably overprecise, but there is quite obviously a difference in expectancy here. A child, an old person, or a woman may engage in sag and pull-together at greater frequency within a time span without being considered as malingering. It is perhaps unnecessary to stress the point that in Dry Ridge the full cross-referencing system is made up of "stiff upper lip" plus "sag and recover." It is perhaps of interest to note that the health image quality behavior of "stiff upper lip" differs from the mood image of anger in Dry Ridge in only two behaviorial aspects that I have been able to trace. First, in eye con-