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The Cultural Construction of Illness Experience and Behavior, 1: Affects and Symptoms in Chinese Culture

The purpose of this chapter, and of the next, is to analyze several common pathways down which cultural beliefs and norms channel illness experiences and patient roles. We will examine cultural influences on cognition, affect, psychophysiological processes, behavior, and social role, and we will study the psychocultural mechanisms that mediate these influences. To accomplish this end, I will discuss a particular instance of culturally constituted illness experience and sick role in Taiwan: the somatization of dysphoric affects and affective disorders. Our concern is to derive an appreciation of the cultural construction of illness in Chinese culture that can be extrapolated to other illnesses and cultures.

The reader is cautioned that after presenting the case material we will make a brief detour through several psychocultural themes in Chinese culture that are prerequisites for our discussion of the cultural patterning of depression and other dysphoric affective conditions. By restricting this analysis I will not consider other ways in which culture affects sickness, such as its frequently important influence on epidemiological determinants of disease.

I present the following case to illustrate somatization and through it introduce the cultural construction of illness experience discussed in this chapter and the next and recapitulate the cultural organization of clinical transactions conceptualized in the preceding chapter. Somatization demonstrates the vital

semantic links between illness and treatment aspects of cultural therapeutic systems. The analysis of the case reveals the utility of the concepts I have introduced to interpret health care systems, their plural clinical reality, and core clinical tasks. It also shows that explanatory models are as central to our appreciation of how illness is culturally constituted as they are to our understanding of the workings of health care. Thus, we can observe the same cultural mechanism at work in the somatizing of psychological distress as illness behavior and in the way it is clinically explained and managed. Analyzing this dynamic activity of cultural construction enables us to build upon our discussion of semantic illness networks and health care systems. Explanatory model transactions point up the cognitive basis of illness experiences just as their analysis discloses the cognitive operations at the heart of clinical practice. It is this cognitive structure that demonstrates most clearly the relationships between patients and healers, illness and healing, and their cultural context.

Our model forces us: (1) to juxtapose the healers' perspectives with those of the patient and family, (2) to relate these divergent perspectives to their concrete cultural and interactional settings, and (3) to assess the sickness episode and the treatment from the various actors' viewpoints. Because I wish to emphasize the interpretive problem created by these divergent perspectives, I have organized the case presentation almost entirely around the different explanations, leaving out data about other aspects of the illness and its treatment. Ideally, this case should be presented as a congeries of the different perspectives of the patient, his family, and the practitioners who were consulted, in which we present the actual words of each actor and describe the therapeutic interactions as they really happened. Unfortunately, I was not able to interview the Chinese-style and Western-style doctors whom this patient initially consulted. Although this account falls short of the ideal, it gives a sense of how a case can be discussed from a broad health care system viewpoint. The upshot is that we see that the ethnomedical researcher needs to apply an "emic" analysis to both indigenous and biomedical EMs, since both are cultural constructs. The concepts we have discussed provide him with an "etic" framework in which EMs can be compared so that

universal and culture-specific aspects of the clinical process can be discerned.

Case 3

Setting and Tâng-ki's EM

We are in the dark, hot, almost airless shrine of a middle-aged Taoist adept, who also is a *tâng-ki* of some fame in Lukang, a large market town on the west coast of Taiwan that was one of Taiwan's largest towns in the Ch'ing Dynasty and that is popularly regarded as a center of traditional Taiwanese culture. The shrine's chief god is Ong-ia-kong, the plague god (see Gould-Martin 1976).

An elderly lady enters and is greeted by the *tâng-ki,* who tells us that she has come several times before with her son for treatment. The son remains outside the shrine, forcing the mother to go out and order him to enter, which he does with obvious embarrassment. The son, who is 22 years old, is thin, well-groomed, fine-featured, shy, and very anxious.

Quickly and without much ado, the *tâng-ki* enters a trance (he is reputedly possessed by the chief god of the shrine). In an undramatic manner he begins chanting in a falsetto, mimicking the formal delivery of characters in Taiwanese folk opera. He directs his remarks (believed to be the words of the god within him) entirely to the mother, paying no attention whatsoever to the son. He tells the mother that he knows the cause of her son's illness. Her son is being attacked by the ghost of a girl who died unmarried and who is pursuing her son and causing his problem. The *tâng-ki* does not name the problem. He advises the mother to make use of some charms he has given her and to burn a large amount of spirit money. He performs no rituals but does listen to the mother's account of the most recent aspects of her son's case and answers a few questions she asks. Then he rapidly comes out of his trance; he gets up and leaves the shrine saying that he has some business to attend to elsewhere. The mother looks quite disappointed (she apparently had other questions to ask), but the son, who stared at the floor in an embarrassed fashion for most of the séance, smiles and looks relieved.

Mother's EM

The entire transaction took approximately ten minutes, of which the *tâng-ki*'s explanation made up less than two minutes.

The mother, speaking to people in the shrine in general, recounts her son's problems in a deeply troubled voice. She says his illness began at age seven, after he was hit on the head with a hammer by an older brother. Since then he has complained of poor memory and difficulty concentrating. He did badly in school and dropped out of middle school before graduation. In more recent years, he has suffered from recurrent bleeding gastric ulcers and other problems: dreaming too much and frequent nocturnal emissions. The last she blames as the real cause of his present condition, since the semen loss causes him to lose *yang* (male principle) and thus produces weakness, fatigue, and lack of energy. The mother reveals her annoyance at: (1) other practitioners of various types whom she and her son have consulted, none of whom has effected a cure; (2) her son, who seems never to get better, but rather goes from one health problem to another; and (3) the *tâng-ki*. She accuses that practitioner (who has already departed, but whose family members remain to hear her complaints) of not recommending the obvious solution if indeed the problem is what he says it is: a "spirit marriage" between her son and the girl's ghost haunting him. She angrily suggests perhaps the *tâng-ki*'s desire is to make as much money as he can by having them return for frequent consultations without completing the treatment.

Patient's EM

The patient tells us that recently he has suffered from stiffness and tenseness in his neck along with insomnia and inability to concentrate at work. He feels weak and remains quite troubled by his chronic ulcer problem. He admits to feeling anxious. He tells us under my direct questioning, he is under great pressure at work, where he is a foreman and has the responsibility both to perform and supervise complicated technical work. He adds that he has few friends, no girl friends, feels very shy, and has neither hobbies nor other interests which give him enjoyment. (When he mentions girl friends he blushes and looks away from us, staring at the floor, much as he did when his mother reported his nocturnal emissions and during most of the *tâng-ki*'s séance.) He also states there are other things bothering him, but he cannot tell us about them at present. The patient reports contact with numerous Western-style doctors and one Chinese-style doctor for his health problems. The former have treated him with many different kinds of medication, including "pep" pills. None of these have worked. Nor did the Chinese-style doctor's medications cure his symptoms. And the patent med-

icine, herbs, and tonics his family has given him have been similarly ineffective. He and his mother show considerable interest in my being a psychiatrist. They ask me what I think is wrong and what I would advise them to do.

Practitioner EMs

The Western-style doctors the patient and his mother consulted told them he was suffering from "neurasthenia" (*shen-ching shuai-jo*), which they understood to signify a physical illness, but otherwise did not know much about. The Chinese-style doctor told them the problem was a "broken kidney" (they seem to mean "kidney weakness" or "kidney deficiency" since those are the terms used by Chinese-style doctors and found in the classical medical texts). They also took that to mean a physical disorder, one producing weakness as well as the other complaints the patient suffered from. Since no medicine had helped him, the patient remained uncertain about these diagnoses, as did his mother. But he let us know he felt even more uncertain about the *tâng-ki*'s explanation, which he came to hear because his mother demanded he come and also because he had failed to get well and remained quite concerned about whether he ever would improve. Therefore, he was willing to try anything.

I was able to carry out a limited mental status examination. It revealed normal orientation, attention, memory, and cognition; no delusions or hallucinations or other signs of psychosis; and considerable anxiety. The patient denied depressive feelings and also denied loss of appetite, weight loss, or any other of the biological concomitants of depression, other than the insomnia he had reported. The patient noted his symptoms were much worse when he was under stress at work. He refused to talk about what else troubled him, but he let me know he would talk about other problems if we could meet privately at a later time. (All the above had occurred in "public" in the *tâng-ki*'s shrine, just as most clinical care in Taiwan takes place in more or less "public" settings, lacking the privacy basic to professional care in the West (see Chapter 7). Because of this, I referred him to a Taiwanese psychiatrist for a full psychiatric evaluation.

My own psychiatric formulation of this case ran as follows: a late adolescent, unmarried male with a chronic anxiety neurosis associated with both acute anxiety reactions provoked by psychosocial stress and a variety of psychophysiological symptoms (somatization and psychosomatic peptic ulcer disease). The latter worsened whenever he suffered an acute exacerbation

of his primary psychological problem. However, I felt this evaluation to be inadequate because of the limited information I had been able to elicit; I expected the evaluation of the Taiwanese psychiatrist to produce considerably more information, especially since the patient appeared to want to talk privately about his problems.

That psychiatrist learned from the patient that he engaged in frequent masturbation, which troubled him greatly because of his fear that he was losing seminal essence (*ching*) representing irreplaceable *ch'i* (vital essence) and *yang*. He believed that the masturbation was dangerous to his health and was the cause of his problems. This made him feel guilty and frustrated because he felt himself unable to stop masturbating and consequently felt condemned to suffer the various symptoms he had, which he was in fact "causing." This psychiatrist diagnosed a sexual neurosis, a problem that in his experience is common among young males in Taiwan. He explained this to the patient along with informing him about normal psychosexual development and also told him that his problem was a psychological one that only secondarily produced somatic complaints; those would disappear after the psychological problem was cured. He recommended tranquilizers and psychotherapy. Although the patient filled the prescription for tranquilizers, he did not return to see the psychiatrist.

Here, then, are different perspectives on the same case. They are not the only ones. Fortune-tellers and *ch'ien* interpreters and a physiognomist all had been consulted, as had several pharmacists, but I did not obtain the details of their explanations.

When he returned to his shrine, the *tâng-ki* was not pleased to find me interviewing his client and was patently disturbed by the referral to a psychiatric colleague. Before we departed and after the patient and his mother had left, he told us that even if the patient suffered from neurasthenia he would not get well until the ghost (*kuei*) was properly taken care of, since that supernatural influence would neutralize any medicine the patient took and counteract the effect of the doctors who treated him by exerting a negative influence on their fates.

DISCUSSION OF CASE 3

The first question to be considered is the nature of this patient's disorder. Everyone agreed that a disorder was present and that it was a physical sickness, but their explanatory models

differed. The patient had no difficulty obtaining consent to take a sick role, but until I consulted him, his psychological symptoms were not considered a separate entity, and no one had suggested an illness that required psychiatric care. The patient and his mother were willing to consider psychiatric treatment because they had failed to secure effective therapy by other means and because I was a prestigious and possibly powerful foreigner.

In Chinese culture, tremendous stigma attaches to mental illness. The concept is employed only to cover psychotic behavior and mental retardation. Minor psychiatric problems frequently are given a medical sick role by the popular culture and by the other health care sectors, including Western and indigenous health professionals. The patient received support and active care, much of it indisputably psychotherapeutic, though directed toward his physical complaints. He obtained release from the obligation to work, the right to stay at home, to be passive, and to seek help from family members, and the legitimation of failure in examinations, work, and interpersonal transactions. As in the Parsonian sick role, he was expected to seek treatment, but not necessarily by professionals. In Taiwan, it is unusual for others to question the patient's right to occupy the sick role.[1] The role frequently is a legitimated mechanism for managing personal and interpersonal problems.

The sick role was redefined as the patient moved out of the family and into the other sectors of the health care system. He moved to a patient role in professional Chinese and Western medical settings, then to a client role in the *tâng-ki*'s shrine, and eventually to a psychiatric sick role, which he quickly jettisoned. Each of these roles involved different expectations and behaviors. As a psychiatric patient, he talked about psychosexual concerns that he would not talk about in his family or in any other patient role. As a client in the shaman's shrine, he engaged in rituals and expected to take part in other healing ceremonies, perhaps including exorcism and a spirit marriage. As the patient of a Chinese-style doctor, he expected and re-

1. My impression is that among Chinese generally the sick role is much more quickly and easily sanctioned than among Americans (cf. Twaddle 1974). Such an impression could be tested in comparative cross-cultural research; I am not aware of any studies to date on this subject.

ceived a physical diagnosis that led to treatment for "kidney weakness," which included herbal medicine and regulation of his diet to treat the "cold" imbalance by eating "hot" foods, avoiding "cold" foods, and taking tonics. He was expected to manage this treatment with the help of his family. In the offices of Western-style doctors he was told that he suffered from neurasthenia. He had expected and received Western medicines, especially by injection. He and his mother still considered themselves to be principally responsible for his care, but they also anticipated that Western-style doctors would be more assertive than their Chinese-style colleagues.

The sick role is not the disorder, but until it is described, we cannot analyze the sickness in terms of disease/illness. This case illuminates the distance between ideal and actual roles. The patient's mother was angered and embarrassed by her son's performance in the shrine. She also was critical of the shaman's performance. And both she and her son exhibited varying degrees of commitment to the different EMs attached to the roles they occupied. In the shrine the mother occupied the prime client role and received the chief attention of the shaman. In the Chinese-style doctor's office and in the Western-style doctors' practices, this situation was reversed. In the psychiatric clinic the mother did not appear at all. That is, in the shaman's shrine the sickness was treated to include the mother, whereas in the psychiatrist's office it was narrowed to exclude all but the patient himself.

Within the boundaries of an agreed-to physical sickness, the patient, his mother, and the practitioners they consulted took different positions on the nature of the disorder. The patient's mother held that semen loss, owing to frequent nocturnal emissions, was the cause of her son's complaints. She felt that loss of *yang* upset the balance between *yin/yang*. But she related this *proximal* cause to two *distal* causes: (1) a supernatural cause, the ghost disturbing her son and (2) a childhood cause (he was hit on the head with a hammer at age seven by his older brother). She combined both causes in her EM, conforming to the tendency of Chinese to see "gods, ghosts, and ancestors" as part of the "natural" world. Included in her concept of the sickness were her son's poor memory, difficulty in concentrating, and poor school performance in childhood; gastric ul-

cers; frequent dreams and nocturnal emissions; semen loss and loss of *yang*; and his current symptoms of weakness, fatigue, and lack of energy, as well as inability to get better even with recourse to a number of different practitioners. This woman presented the whole as if all the parts fit together logically. The mother's ideas about cause related directly to specific treatment interventions. That is, her EM functioned to open up behavioral options. She helped her son obtain access to virtually all of the available interventions. This series of actions was an entirely pragmatic hunt for a treatment implicated by her model that would remove her son's complaints. Frustrated by repeated failure, she was even willing to entertain psychiatric treatment, with the stigma surrounding it.

The childhood event in her EM supported her claim that this son differed from his siblings, and explained why he had suffered repeated problems in school and social relationships. Like the supernatural element, it attributed responsibility for the problem to something other than herself or her son.

Her son did not express his ideas fully in the presence of his mother. He did not hold to either the childhood or supernatural causal notions but utilized other components in his explanatory model. He believed he had a physical disorder, neurasthenia, caused by masturbation. He lumped his anxiety together with these other problems. He viewed himself as the cause of his illness, since he found himself unable to cease masturbating, and regarded that as the shameful and real cause of his physical sickness. While noting stress at work, recurrent anxiety, and interpersonal problems, at no time did he suggest these were evidence of mental illness. His failure to return to see the psychiatrist strongly suggested that he rejected a psychiatric illness label. He included psychosexual factors and interpersonal stress in his explanatory model, however, so that it was psychologically more sophisticated than his mother's model.

The Chinese-style doctor applied a classical Chinese medical notion of kidney insufficiency (*shen-k'uei*). This concept often subsumes hormonal and sexual problems (including impotence) as well as weakness and neurasthenia in contemporary clinical usage. But it was reported as "broken kidney," which either was a transform applied by the clinician or, more likely,

a distortion on the part of the patient and his mother. Here a functional metaphor in the classical Chinese medical texts (insufficient strength of the kidney in terms of the putative functional interrelationships of the kidney and other internal organs) has become a structural metaphor: the kidney as an independent organ is "broken." (The patient said this pointing to his right flank.) This concept further denotes a symbolically "cold" disorder. But the concept's assocations were not fully appreciated by the patient or his mother.

Under kidney weakness, cold disorders, neurasthenia, and other related terms, Chinese-style doctors label a large variety of sicknesses. Some of these overlap with what Western-style doctors and psychiatrists label as hysteria, anxiety neurosis, depression, psychophysiological problems, hypochondriacal personality, etc. Most of these problems are accompanied by somatic complaints. It is the somatic rather than the psychological complaint that is the focus of diagnostic and therapeutic interest in Chinese-style and in Western-style medical practice in Taiwan. This is the case as well in the popular sector. The Chinese-style doctor may refer to psychological complaints, but does so in terms of a physical disorder with a reputed organic pathophysiology.

Western-style doctors do much the same thing, making use of a concept such as neurasthenia as if it were a physical disorder. Among themselves, Western-style doctors will use terms like depression, anxiety neurosis, hysteria, and mental illness and will describe neurasthenia most frequently as a psychological disorder; but with their patients, neurasthenia generally is used to convey the idea of a physical disorder and the other terms are avoided. Neurasthenia is the single most commonly used label for sanctioning a medical sick role for minor psychiatric and interpersonal problems in Taiwan.

Chin and Chin (1969) point out that this term was picked up with great interest in China before 1949, where it was frequently used as a label of sickness. With the Communist victory in 1949 this label quickly went into disuse. The Communists held that it was a disorder produced by capitalism and a problem characteristic of middle-class intellectuals. This disorder, they further held, was incompatible with socialism, where socially productive labor would prevent intellectuals

from succumbing to it. Whatever its vicissitudes were in China over the past several decades, neurasthenia now again is in very wide use and appears to function in the People's Republic in precisely the same way as it does in Taiwan.

Neurasthenia has passed out of the diagnostic manuals of the medical profession in the West. Sir George Pickering, an eminent English physician, notes this term was used in the 1920s when he was a medical student and was defined in Osler's textbook, which he used, in the following way: "A condition of weakness or exhaustion of the nervous system, giving rise to various forms of mental and bodily inefficiency. The term covers an ill-defined, motley group of symptoms, which may be either general and the expression of derangement of the entire system, or local, limited to certain organs; hence the terms cerebral, spinal, cardiac, and gastric neurasthenia." (Pickering 1974: 166.)

Pickering goes on that neurasthenia is now recognized as the manifestations of psychoneurosis. There is much to suggest that early in the century and during the First World War this term was used in England and the United States as it currently is used in Taiwan and the People's Republic of China: to cover minor psychiatric disorders under the more respectable mantle of physical disorder. This usage was probably introduced by Western medical men and medical missionaries in the late nineteenth and early twentieth centuries.[2] The Western-style doctors consulted by our patient and his mother seem to have applied the term in just that sense.

The Chinese term for neurasthenia, *shen-ching shuai-jo,* conveys the same vague idea of organic pathology that the term connotes in English. *Shen-ching* means neurological and *shuai-jo* means weakness (in the classical Chinese medical senses of physical weakness and weakness of the body's processes leading to sickness). The picture is of an ailment involving non-

2. An interesting question for cross-cultural comparisons would be how neurasthenia has been used in other cultural settings and under what circumstances it has played a similar role to that I have described for Chinese culture. The larger issue implicit in that question is how mental illness is evaluated (i.e., whether it is stigmatized or not) in different cultures. A simple comparative analysis of this issue based on recorded ethnographic findings should be feasible for many cultures.

specific signs and symptoms associated with a "weakness" of the nerves and a general "weakness" of the body produced by the weakness of the nerves. In Taiwan, it is common to hear practitioners classify neurasthenia into two chief types: neurasthenia primarily involving the "nerves" or "brain," and "sexual" neurasthenia. The latter includes a wide variety of sexual problems, including impotence, hysteria, and excessive masturbation. Besides these major types of neurasthenia, one less commonly hears about neurasthenia involving the heart.

As Pickering notes, neurasthenia is no longer used as a diagnostic category by physicians and psychiatrists in the West. Instead they use the labels I have used for the diseases most frequently subsumed under neurasthenia. Hence, I and the Taiwanese psychiatrist characterized this case respectively as anxiety neurosis with somatization and sexual neurosis with somatization. I formulated the patient's *disease* as a psychological disorder with physiological manifestations that included peptic ulcer. The *illness* was his experience over the years in trying to cope with this disease. The onset of the disease was probably insidious, beginning in late childhood. The ulcer symptoms were a direct physiological correlate of his disease, and the substitution of nonspecific physical complaints for psychological complaints, i.e., the somatization of the mental disease, expressed the cultural patterning of his illness.

Masturbation was a component of his anxiety neurosis that carried particular cultural significance. The Taiwanese psychiatrist, who obtained more information than I did, thought that the anxiety was secondary to another constellation of psychosexual problems: (1) excessive masturbation associated with feelings of guilt *and* shame; (2) misinformation about normal sexual development, which contributed to the guilt and shame and which in large part resulted from the peculiar way issues concerning sexuality are handled (or more precisely, avoided) in Chinese culture;[3] and (3) a specific "culture-bound" illness (*shen-k'uei,* "kidney deficiency") characterized by the belief

3. The question of how sexuality is handled in Chinese folk culture falls well outside the scope of our concern, but it is directly relevant to understanding Case 3. Hsu's brief analysis (1949, 1971a) of this question relates the discrepancy between utter suppression of public and parent-child talk about sexuality and the presence of (and frequent resort to) brothels, concubinage,

that masturbation produces an irreplaceable loss of *yang* that leads inexorably to a disorder with physical complaints similar to those he was experiencing. The Taiwanese psychiatrist held that this problem occurred fairly frequently among adolescent and young adult males in Taiwan, whom he considered to be suffering from a culturally specific form of sexual neurosis. This is not a diagnostic term in most psychiatric nosologies employed in the West, although symptoms related to masturbation in adolescents are also quite common but labeled in other ways. The term represented this psychiatrist's attempt to place our case with others that exhibited the same features and that seemed to originate in an interplay of biologically based behavioral problems and Chinese cultural problems concerning psychosexual development.

No single, unified modern psychiatric explanation can be applied to this case. Modern psychiatry contains multiple (and at times conflicting) explanatory models (cf. Lazare 1973). A psychoanalytic model will stress the patient's early childhood development as it relates to his unconscious conflicts. A behavioral model will stress the current environmental and psychological contingencies reinforcing the patient's deviant behavior. A social model will place emphasis on the role of stress in this patient's work and family. A psychobiological perspective will underscore neurobiological processes. Each explanation selects different clinical evidence to build an argument, just as I constructed an argument from the various EMs. And each, in turn, will lead to a specific treatment approach, just as the differing patient, family, and practitioner EMs led to

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and a highly developed erotic tradition in traditional Chinese culture to the situation-oriented structure of that culture. The child learns nothing about psychosexual development in his home or at school and is taught to suppress all outward signs and questions concerning that topic. On the other hand, in adult life with his peers and in married life, sexuality will be handled directly in appropriate settings. Adolescence, then, presents a tremendous problem, as certain of our case illustrations reveal, since masturbation, sexual relationships, and general sexual interest, stimulated in part by hormonally dependent psychosexual development, are faced with total suppression in the context of the family, where such feelings and activities are held to be shameful and are said to lead to loss of vital essence and, potentially, to illness.

different treatments in this case. These explanations will be much more psychologically oriented than those applied by the patient, his mother, and the various non-Western practitioners they consulted. They show the psychological orientation of Western society. That culturally patterned orientation has been transferred in the modernization process to Taiwan, and to the professional sectors of other non-Western societies, where it is usually in striking contrast with indigenous beliefs and values.

The health care system orientation leads me to place different perspectives side by side, my own included. By so doing, I am able to piece together a total picture of this patient's system of care. This approach compels me to move outside of the ethnocentric and medicocentric confines of my role as a psychiatrist. Of course the patient and his mother were quite conscious that they were actors among an array of differing forms of medical knowledge and action; a social scientist may find little that is surprising here. But this perspective creates real problems for practitioners trained to see illness and care only from their professional point of view. One of the chief virtues of ethnomedical and cross-cultural research is that the medical, psychiatric, or public health practitioner finds himself lifted out of his narrow professional orientation and exposed to all the aspects of health care that are frequently hidden from him by the role and social space he occupies in his own culture. That alienation offers him a much needed sensitivity to the larger health care system, as well as to the impact of culture on that system. He sees distinctive semantic illness networks as well as alternative clinical realities with quite different directions for treatment. It remains unclear, however, how the clinician will go about comparing and mediating these different perspectives, though we have set out one method by which the ethnomedical researcher can do this. Indeed, in the case just presented, I remain uncertain how I, as a clinician, can relate the differing points of view to my own professional orientation to derive an appropriate basis for intervening. Nonetheless, the broader framework seems to me to be of potential clinical use; perhaps it provides the only method for unifying treatment, even if it was not applied here in that way.

If we turn back to the Prologue's description of a local health care system in Taipei, we should now find ourselves prepared

to see that the separate components described there are related to each other in a unique cultural system. The description in the Prologue did not reveal a "clinical system," since no specific case of illness was described whose trajectory through the system demonstrated the clinical reality composed by the separate parts, but our case shows how a particular illness experience brings various elements of the health care system into an integral structure.

The case also suggests how this cultural system shapes illness both through the categories we employ to label and explain disease and through the influence of those categories on the way we perceive and experience symptoms. I will now examine this meaning-mediated relationship between culture and illness in more depth as it is revealed in the cultural shaping of affects and affective disorders in Taiwan.

CHINESE CULTURAL PATTERNING OF AFFECTIVE EXPERIENCE AND BEHAVIOR

1. *Expression of Affect*

I shall describe in this section only those background themes bearing directly on our subject. The review is highly focused, yet I feel that it is also a tentative and incomplete account of Chinese cultural categories and values that affect disease and illness.

During their primary socialization, individuals in Taiwan learn that their own personal affects, especially strong and negative ones, should not be openly expressed (see Hsu 1949, 1971b; Solomon 1971; Tseng and Hsu 1969). They learn that doing so will endanger close interpersonal relationships whose harmonious arrangement is more important to them than their own psychological status. Their well-being, in fact, depends on these finely balanced relationships. Revealing their own feelings might result in shame for themselves and their families. Concomitantly, close interpersonal relationships, not intrapsychic experience, are of primary interest and importance (Hsu 1971b). The family is an entity that existed before one was born and will exist after one is dead. Through the family and ancestor worship, the core of Chinese religion (A. Wolf 1974), people are part of an immortal vehicle. Their place in that vehicle assures their link with past and future, offering them per-

sonal and cultural meaning transcending death. Their tenure in the family places upon them privileges and obligations, the chief of which is to improve the family's fortune, while not bringing shame on it. Related to this obligation is another, requiring them to treat their own person and body as if they are as inviolable as the family.

Since neither fully belongs to them alone, injury to the person is in part injury to the family. The family is frequently thought of in Taiwan as a circle whose perfect roundness symbolizes the ideal of harmonious integration of all individual members (Jordan 1972). Children learn that within that circle are the most significant meanings and transactions in their lives, and that how others come to regard and value them determines and is determined by how they regard their families. Achievement is not only for them, but also for the family. Shame falls on them and on their families together. Misfortune, including sickness, affects both.

As Hsu points out (1971b), the chief model for the individual's interactions in society is the father-son dyad. The ancient Confucian relationship is still thriving in Taiwan. That relation is the template for relationships with teachers, supervisors, those older and socially superior as well as those younger and socially inferior. It acts as a model for practitioner-patient relationships. As a cultural metaphor it holds significance for almost all other relationships. It constrains the individual, among other things, from revealing his personal emotions openly. Even more strikingly, it invests intimate relationships with more affective significance than one's own thoughts, fantasies, desires, and emotions. Family and other close interpersonal relations become a person's paramount interest; coping with them becomes a sign of adult competence, and problems with them are more important to him than other personal problems. The worst problems are family problems. Emotions are expected to be appropriate to situation and family setting, and they should be managed in reaction to external events. There should be ongoing reflexive monitoring of how others perceive how one feels and acts, and this information should be used to interpret and modulate one's behavior to respond appropriately to others.

These things are constantly reinforced in the family. As a

young child, for example, the individual must observe *hsiao* (filial piety), *pao* (reciprocity in social relationships), and other virtues. "Face" is as much due to success in maintaining these relationships as success in the larger world (Hsu 1971a, 1971b; Hu 1944; Yang 1957). When personally upset, one is to "endure" disturbed feelings, and not to value them over those of parents and sibs. Excessive expression of emotion, the Chinese child is taught, will upset the harmonious functioning of the body and cause disease. When physical complaints accompany psychological complaints, family members attend only to the former. Indeed, in such situations, the individual learns a much more sophisticated set of terms and beliefs for somatic distress than for psychological distress. And one learns to talk about the latter in terms of the former, just as care for the latter results indirectly from care given to the former. Family members, friends, and teachers do not apply negative terms to physical complaints, as they do to psychological complaints. Physical sickness, not emotional distress, is an excuse for failure in school, sports, work, personal transactions, and sexual relations. Children learn that others will rarely challenge the legitimacy of their physical sicknesses and medical sick roles. But psychological excuses lack social efficacy and at times suggest the stigmatized domain of mental illness.

The Taiwanese individual speaks Hokkien and Chinese, languages rich in terms for bodily states and their dysfunctions, and for interpersonal transactions and their problems, but relatively impoverished in psychological terminology. People learn not to attend to their feelings, and acquire little skill in identifying emotional states. Non-specific names lump together emotions that contemporary Westerners readily differentiate. Moreover, many terms for emotional states (e.g., *mên*, depressed or troubled; *fan-tsao*, anxious or troubled; *kan-huo*, angry; *hsin-ching pu-hao*, generalized, non-specific emotional upset, bad spirits; etc.) express emotion in terms of bodily organs (*mên* and *fan-tsao* contain the heart radical; *hsin* is the word for heart; *kan* is the word for liver). In classical Chinese thought, and even today in Taiwanese popular thought, the heart is regarded as the seat of the emotions and the liver as the bodily agency associated with anger. When people use these terms, they not infrequently point to the chest and to the right upper

abdomen. The terms link feeling states and physical symptoms with interpersonal relations and their problems (see Figure 4 in Chapter 3). This semantic network expresses emotion in bodily imagery and constitutes it in bodily experience (cf. Leff 1977, for similar examples from other cultures including traditional Western society).

In interviews and psychotherapy with Taiwanese, I found ideas and feelings were frequently divided into those held to be superficial and public and those held to be deep and private. The former were available upon questioning, and from a contemporary Western perspective, they were shallow, unreflective, unsophisticated, and conventional. The latter, on the other hand, were never shared with anybody, except on special occasions with intimate friends. They were held to be utterly personal and were protected from others. Many informants asserted that these deeply held ideas and feelings were virtually the only privacy they possessed. To ask about or freely talk about such matters was "embarrassing" and "shameful." The cultural norms governing interpersonal transactions protect one from ever having to communicate one's most private inner world, and tend to keep the door to this inner sanctum closed, even to the individual himself. Most patients and informants I pressed about this subject used denial and displacement to block or divert my inquiry. Even after relationships of trust were established, and even in the course of short-term psychotherapy, I found it extremely difficult to elicit personal ideas and feelings—in part because the orientation of most people was outward rather than inward and individuals had remarkably little past experience with self-scrutiny to draw upon. These findings, quite obviously, contrast strikingly with those to be found among most middle-class Caucasian Americans.

Socialization into Chinese culture leads individuals to be preoccupied with the concrete situational context of personal problems, rather than with their experiential effects (Hsu 1949, 1971b). When enmeshed in family, business, or school problems, individuals are oriented to external causes and practical remedies. This fundamental attribute of Chinese cognitive style (Nakamura 1960) conveys personal ideas, values, and feelings *indirectly* through descriptions of situations. Personal com-

ments are added as one observes the listener's response. This is a method for saying what the other agrees with and withholding what the other responds to negatively. Since the listener is also skilled in this process, interpersonal transactions with significant others are characterized by a mandate for mediation, harmony, and consensual agreement. They are not characterized by the direct and full expression of individual points of view. (The commonly observed verbal aggression between strangers in the street or marketplace that marks relationships that are not culturally significant simply discloses the reverse side of the behavioral paradigm.) At times, traditionally oriented Chinese seem to hold personal views completely anchored in the concrete situation at hand, so that each situation gives rise to a "new" view produced by a cautious, indirect disclosure of mutually shared opinion. But at the same time, there is little doubt that quite divergent views are held. In master-disciple relationships, the beliefs of the dominant person are treated as authoritative, and in relations with peers separate opinions that contradict a conventional viewpoint are simply withheld or understated. These traits of Chinese culture are well known to students of that subject.[4]

4. Most, if not all, of what I have discussed in general terms has been recognized and more precisely described by students of Chinese culture and behavior, including those whom I have previously referred to in this and other sections: C.C. Chen, personal communication; Chiang 1952; C.C. Hsu, personal communication; Hwu 1975; Y.H. Ko 1973, and personal communication; Lin 1953; Rin et al. 1966; M. Wolf 1970; Yap 1974. What I have said here holds, I believe, for Chinese generally in Taiwan and other traditional Chinese cultural settings, but it almost certainly requires major modification for Chinese in the People's Republic of China, although I am not sure what kind of modification, and perhaps also for women in Chinese society (M. Wolf 1972; Wolf and Witke 1975). Our description also needs to be modified before it can be applied to Chinese-Americans (cf. Kingston 1977; Sue and Wagner 1973). Even though modernization in Taiwan and other Chinese cultural areas clearly has changed traditional behavioral paradigms, I do not believe those changes have been radical enough to challenge the validity of the general framework. Listing such a series of concise generalizations is bound to make a complex behavioral field appear superficial and one-dimensional. But, at the possible expense of turning an ideal-type characterization into a caricature, these few paragraphs do set out in a very short space what I take to be the abiding symbolic meanings and norms guiding individual behavior in "traditional" Chinese culture.

The pattern I have described is one in which the family inhibits the expression of dysphoric or strong affects; people examine and express only superficial and usually shared ideas and feelings and tie their feelings to concrete interpersonal transactions and situations; individuals are more interested in managing close interpersonal (mostly family) relationships than in delving deeply into their own interior psychological states; people gain more facility in describing interpersonal than psychological problems; and they substitute physical for psychological complaints.

2. Cultural Patterning of Symptoms: the Somatization of Dysphoric Affect

In Taiwan and in other Chinese societies patients rarely complain of anxiety, depression, and other psychological problems. Seventy percent of patients with documented psychological disorders who visited the Psychiatry Clinic at the National Taiwan University Hospital initially complained of physical symptoms (Tseng 1975). The overall incidence of major psychiatric problems in Taiwan, with possible exception for psychoneurotic disorders, seems to be roughly the same as in the United States (Lin 1953; Lin et al. 1969). While Singer (1975) claims that the prevalence of depression amongst Chinese is probably not significantly different than in the West, this impression has not been established with any certainty. What has been determined is that in Taiwan patients with depression do not complain of feeling depressed to psychiatrists, but instead go to internists or general practitioners for treatment of the biological concomitants of depression (insomnia, weight loss, dry mouth, constipation, loss of energy, etc.). In the United States such patients are frequently found in psychiatric clinics complaining of feeling depressed, though some, particularly members of ethnic minorities from lower-class backgrounds with limited education, still are to be found complaining of somatic symptoms in medical clinics. This major discrepancy in the phenomenology of depression in American and Chinese populations (Kleinman 1977a; Tseng 1975; Yap 1965), must be explained by the cultural patterning of this illness. The *illness* is markedly different, but the *disease* would be the same in both populations.

Let us again consider the sickness of the young male Taiwanese patient in the *tâng-ki*'s shrine. The disease is a chronic anxiety neurosis, with actue exacerbations that are stress-related and associated with psychological and somatic symptoms. American patients would report both the psychological and the somatic manifestations to the doctor. However, they would focus on anxiety as the main complaint. Along with this complaint, they would report other psychological difficulties. In Taiwan this does not happen very often. Our patient, like the great majority of Chinese patients, reports physiological symptoms generated by the high level of anxiety affecting the autonomic nervous system and the structures it innervates. The focus is on anxiety-induced symptoms, such as the Taiwanese patient's gastric complaints, as well as insomnia and fatigue. Other complaints associated with autonomic nervous system hyperactivity caused by intense anxiety are rapid heart rate, often with accompanying chest discomfort, hyperventilation, sweating, tremors, diarrhea, and abdominal discomfort, and a wide variety of other complaints, including amenorrhea and impotence. Any of these might be reported, and frequently a number occur together. Non-specific complaints such as weakness, malaise, loss of appetite and other interests, frequent dreams, and hypo- or hyper-sexual behavior also occur, as in the case of our Taiwanese patient. When the anxiety state becomes chronic, for personal and social reasons, a specific configuration of complaints is patterned (the illness). Personal experience and physiological status play an important role in determining which organ system will be affected (Lipowski 1973, 1977). Cultural, along with personal, meanings influence which kinds of stimuli are perceived as stressful, and those perceptions in turn provoke anxiety and the somatic symptoms associated with it. Cultural beliefs and experience help determine which symptoms are most threatening and bothersome. This is exemplified by the cases we have described involving Chinese-American and Taiwanese patients who believed they were suffering from sicknesses due to loss of *yang*. Such psychophysiological syndromes mimic other diseases and often are not readily diagnosed.

In Taiwan and the United States many patients in general medical practice suffer from somatic complaints that are due

to psychological problems. Estimates are that up to 50 percent of all patients in general medical practice may fall into this category both in the United States (Stoeckle et al. 1964) and Taiwan (Kleinman 1975b and c). All of the patient's symptoms in Case 3 can be attributed to anxiety and its various physiological manifestations. I have also described Chinese-American patients at the Massachusetts General Hospital who suffered from physical symptoms (insomnia, loss of weight, weakness, dizziness, fatigue, non-specific and chronic pains), all of which could be attributed to the autonomic nervous system correlates of depression (Kleinman 1977a). These patients' illnesses represent the patterning of the underlying disease by cultural determinants that yield characteristic types of somatization.

For example, in other cases of anxiety neurosis in Taiwan, the illnesses are frequently characterized by chest and heart discomfort. In Chinese the term *fan-tsao* (anxiety, trouble, worry) includes, as we noted, the radical for heart. This radical is used in many Chinese characters related to emotional states, since the heart was the seat of the emotions. Similarly, emotional upsets are referred to by expressions that use the heart as a metaphor. The linguistic association of heart and affect, heart disturbance and disorders of affect[5] supports the tendency to locate tension or angry or despondent feelings in the chest and the heart. Many patients I interviewed associated a psychological state with the heart. In one patient chest discomfort may have been related to anxiety-induced tachycardia or dyspepsia with esophageal irritation. In such cases, the secondary physical symptom is verbalized and responded to, rather than the primary problem. Chinese culture defines the somatic complaint as *the* primary illness problem.

Another example is the term *mên* (depressed). The character for this term includes the heart radical enclosed within a doorway radical. Patients and informants told me they picture this

5. Although semantic sickness networks involving somatization via psychosomatic metaphors for the "heart" are found in Western and other non-Western cultures (cf. Good 1977; Leff 1977), the particular configuration they take on in Chinese culture is unique, as I demonstrate in this and the following chapter. Hence, somatization is a coping strategy found in a number of different cultures, but it varies among cultures both in the degree to which it is employed and in the specific symptom and behavioral patterns it presents.

character when they used the term. Their hearts were "locked in," "closed off," or "suffocating behind a door." They pointed to their chests to locate the feeling there. To them *mên* meant this physical sensation and its associated psychological state. The metaphors communicate how they feel in physical imagery in which the affect is inferred. The physical imagery rather than the affect is most real. The idiom makes the experience primarily somatic. Chinese patients who are psychologically depressed sometimes complain that they feel something "depressing" into their chests or "pressing down" on their heads. Thus, quite commonly, physical complaints serve to describe psychological as well as physiological states and are so understood by adults. The term for "depression" as a symptom in the psychiatric lexicon in Taiwan, *yu-yü,* is rarely used by patients because it lacks the psychophysiological meanings of *mên* and cannot function as a somatic metaphor.

I often have felt exasperated and quite helpless trying to get Chinese patients to talk about a specific dysphoric affect. Patients who have told me they are feeling depressed or anxious or frightened, for example, seemingly cannot go beyond naming the feeling. Unlike middle-class Caucasian-American patients with similar disorders, who will often describe the dysphoric affect in considerable detail and relate it to many different aspects of their lives, Chinese patients commonly move directly from naming the affect to the situation they believed caused it or to its somatic and interpersonal concomitants. They will not elaborate upon its intrapsychic characteristics and state that they do not themselves think about it in such terms. They appear to lack more refined terminology for what they are feeling. This is not merely a function of suppression or denial, since they were willing to talk about emotions and personal problems and were frustrated by our mutual difficulties in exploring their disturbed feelings. Indeed, an important aspect of psychotherapy with such patients is teaching them a language to communicate their intrapsychic experiences, especially disvalued ones. I saw such patients in the Department of Psychiatry, National Taiwan University Hospital in short-term (4 to 15 sessions) psychotherapy. I interviewed ten of them in Chinese and eight in English. I interviewed 15 additional patients in Taiwanese with the help of native Taiwanese

speaking assistants. Moreover, my experience is confirmed by psychotherapists who are native Chinese speakers (cf. Tseng and Hsu 1969; Hsu and Tseng 1972; Gaw 1976). I have had similar results in psychotherapeutic interviews with 35 Chinese patients in the United States, many of whom were fluent in English. Hence, I do not believe my experience is a result of errors in translating or inadequate command of language.

Let us examine other examples of the cultural patterning of symptoms in Chinese culture. *Huo-ch'i ta* is a common expression used by patients to refer to a set of complaints, and by Chinese-style doctors to indicate a pathophysiological phenomenon believed to underlie those symptoms. The meaning this term possesses among Chinese-style clinicians is restricted. They refer to an excess of hot energy or "fire" rising in the body as a pathological excess of the energies or "fires" of the five internal organs (*wu-tsang*): liver, heart, spleen, lung, kidney. Following Porkert's (1973) terminology for translating classical Chinese medical concepts, it is an "orbisiconographic" idea symbolizing the disordered interrelated functions of the internal organs. But as presently applied by Chinese-style doctors in Taiwan, it often glosses simply as inflammation. Chinese-style doctors and patients associate it with too much heat "rising up" from the lower abdomen toward the head. The metaphoric range of meaning this term holds for patients is much wider than its technical meaning in the indigenous profession of medicine. Some patients regard it as actual fire rising up within them. One patient complained to me of fire burning the nerves of his chest, just as a real fire burns wood or an electrical appliance. Whereas for Chinese-style doctors the subject of *huo-ch'i* is *ch'i* (vital energy), for patients the subject is *huo* (fire). A burning sensation caused by gastric irritation or hypersecretion of gastric acid with esophageal reflux is a commonly reported sensation in the United States and Taiwan. In the United States metaphors like "burning acid," "trapped gas," and "open sore" are used to describe this complaint, whereas in Taiwan *huo-ch'i ta* is applied to this sensation. The label exerts some influence on the symptom for *huo-ch'i ta* is not limited to abdomen and chest but "rises up" into the mouth, where it produces a sense of the gums swelling, bad taste, bad odor, and throat irritation. For many people the essence of *huo-ch'i ta* is in the mouth, but a range of meanings

are attached to the term. In the popular sector it covers what I take to be acute viral disorders with gastrointestinal and upper respiratory manifestations, but it also includes symptoms associated with chronic disorders. People routinely employ the term to label the symptoms of different disorders. Once the label is applied it remains unclear to what extent the expectations alter the very nature of the symptoms, but something of this kind might well happen. Patients describe feeling out of sorts, in bad spirits, dull, easily angered, unhappy, and having difficulty concentrating and lacking energy. Many whom I have interviewed suffer insomnia, loss of appetite, and headache along with *huo-ch'i ta*, and they associate it with problems I would diagnose as depression or psychophysiological syndromes. Thus, *huo-ch'i ta* may at times generate somatization.

Symptom terms may be unique to a specific cultural context. For example, Chinese patients not infrequently refer to a somatic complaint of *suan* (literally sourness) in limbs, joints, and other bodily locations. Sometimes they complain of this feeling throughout the entire body. When I questioned patients, they denied it meant "ache," "pain" or "soreness," and stressed the quality of "sourness" as the essential characteristic. Sourness in the classical Chinese medical system of correspondences relates to the phase Wood and the hepatic functional system of the body (Sivin 1975), but most patients had little or no understanding of this system. When I explained it to them, they made it clear that they meant only the flavor, yet I still wonder whether the classical symbolic associations persist in the popular culture. I have not come across this symptom among non-Chinese patients, nor am I aware of it being reported in the clinical literature. In a few cases of arthritic joint pain and low back pain, as well as in several cases of generalized malaise associated with viral infections, I have asked Caucasian patients in the United States if they could identify "sourness" in their limbs or joints and they have not recognized such a sensation. Yet these are disorders in which Chinese patients complain of *suan*. Several Chinese patients have complained of *suan* affecting their hearts. Each was recovering from the death of a parent and appeared to be actively grieving, yet this physical complaint was presented instead of the feelings of loss and sadness.

Suan is not the only instance among Chinese of a culturally

unique symptom; another example is *t'ou-yün*. Western-style doctors frequently translate this to mean dizziness, but it is a more specific sensation than that. Patients and informants report the sense that a film has been placed before the eyes so that images appear hazy. Associated with this core symptom are complaints that things outside the body are moving and that you feel like you will fall down. Thus, this term can incorporate at once both dizziness and vertigo, which modern scientific medicine distinguishes as two separate symptoms. Patients differentiate *t'ou-yün* from *t'ou-t'ung* (literally head pain, the most common general term for headache) and *t'ou-chung* (a sensation of fullness or heaviness in the head). All three symptoms are aspects of headache. There is general agreement on the meaning of *t'ou-yün*; like *huo-ch'i ta* it is associated with both physiological and psychological (insomnia, bad spirits, fatigue, irritability) features. Use of the term dizziness has passed from the United States to Taiwan in the textbooks and has distorted the perception of clinicians in Taiwan, who often miss the popular meaning conveyed by *t'ou-yün*.

Patients in Taiwan employ these and other terms to refer to problems affecting the brain more commonly than they employ terms to refer to psychological complaints. Thus, they often refer to *sensations* of damage affecting "brain nerves" (*nao-chin*). Expressions of primary symptoms related to the brain are rare in the contemporary West. Clinicians may diagnose brain damage, but Western patients usually complain of such problems in psychological terms. When we examine complaints of "brain nerve" damage among patients in Taiwan, we do not find neurological pathology but depression, anxiety neurosis, hysteria, psychophysiological reactions, and so on.

Here again we have examples of the cultural patterning of symptom perception and communication. I could adduce other Chinese symptom and affect terms to further substantiate this thesis, but I think the point has been made well enough. Similar examples could be cited for other cultures, including our own. "Colds," "hyper-tension," "lumbago" or "backache," "nerves," "lump in the breast," "upset stomach" are terms that need to be situated in the semantic illness networks particular to contemporary American popular culture before they can be adequately explicated. They, too, convey both cultural

and personal meaning. It is this meaning-centered aspect of affects and symptoms that requires detailed ethnographic and clinical description. Biomedical and psychological reductionism strips away what is most unique to these terms and the experiences they constitute and express. To correct this distortion ethnomedical and ethnopsychiatric research must provide phenomenological accounts of common symptoms and affects for different cultural systems. Such accounts, which are not abundant, are needed to establish the grounds for delivering psychologically and culturally appropriate clinical care; hence, they are a key desideratum for anthropologically oriented medicine and psychiatry.