DEPRESSION, SOMATIZATION AND THE "NEW CROSS-CULTURAL PSYCHIATRY"

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Abstract—Contrary to Singer's contention that the features of depressive disorders do not exhibit significant cross-cultural differences the author uses material from field research in Taiwan and data from recent anthropological and clinical investigations to support the opposite view that such differences exist and are a function of the cultural shaping of normative and deviant behavior. Somatization amongst Chinese depressives is used as an illustration. This discrepancy reflects substantial changes in the nature of more recent cross-cultural studies by anthropologists and psychiatrists, changes which are giving rise to a new cross-cultural approach to psychiatric issues. Some features and implications of that approach are described.

INTRODUCTION

Singer's [1] review of cross-cultural studies on depressive disorders in a recent issue of this journal "concludes that there is insufficient evidence to support a prevalent view that depressive illness in primitive and certain other non-Western cultures has outstanding deviant features." Many researchers who have studied human behavior and deviancy cross-culturally will find Singer's conclusion disturbing and a good number will believe it to be wrong. A careful reading of Singer's review discloses much that is amiss with what I shall call the "old transcultural psychiatry." Drawing attention to these problems also gives an opportunity to briefly introduce theory and findings from a rapidly developing interdisciplinary field which I shall call the "new cross-cultural psychiatry" and to contrast the latter with the former over the question of culture and depression.

WHAT IS WRONG WITH THE "OLD TRANSCULTURAL PSYCHIATRY"?

Like Singer's review, much of the work has involved a breathless search through large amounts of data from different societies looking for "universals". Since most findings were collected in dissimilar ways by researchers working with different methods and hypotheses, the results of such literature searches are disturbingly alike the conclusions are superficial and most of the interesting and more depthful issues are cast aside as unproven and incomparable. Although the chief concern of transcultural psychiatry has been to determine the relative distribution and frequency of particular kinds of mental illnesses in different societies by using epidemiological methods, only a very few studies make systematic cross-cultural comparisons. The Dohrenwends [2] demonstrate the failure of most psychiatric epidemiological studies to successfully evaluate the impact of basic social and cultural factors on psychopathology, and the studies Singer reviews illustrate the same problem. The question of culturogenesis of mental illness, which has preoccupied many of these studies, remains unanswered but seems to be leading to a dead-end.

As Singer notes, chief amongst the difficulties is the absence of universally accepted definitions of psychiatric disorders such as depression. Lacking that, cross-cultural studies of depression, for example, do not study a single phenomenon. Dysphoric affect, normative depressive states, and various behavioral deviances are lumped together. After calling our attention to this failing, however, it is hard to see how Singer pushes ahead to the conclusion we have already quoted. His conclusion is no more supported by the studies, given his critique of their limitations, than is its opposite. Just as Singer eliminates a wide range of other solution-approaches that have been erected to resolve the question of culture and depression, so must his conclusion be eliminated.

But the problems raised by Singer's article go beyond the fact that we still lack a comparative epidemiology of depression which can apply the same disease category and the same diagnostic methods in different social and cultural settings. Indeed the chief question emerging from the traditional transcultural psychiatric approach is whether the quest for such a comparative epidemiology is itself an obstacle to understanding how culture affects depression.

Following Klerman [3,4], amongst others, we can isolate a depressive syndrome characterized by depressive affect, insomnia, weight loss, lack of energy, diurnal mood changes, constipation, dry mouth, and an apparently limited number of related psychological complaints. Singer is right in suggesting that this syndrome appears to be present in a number of cultural settings. But he is not correct when he uses this fact in support of his conclusion. The depressive syndrome represents a small fraction of the entire field of depressive phenomena. It is a cultural category constructed by psychiatrists in the West to yield a homogeneous group of patients. By definition, it excludes most depressive phenomena even in the West because they fall outside its narrow boundaries.

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Applying such a category to analyze cross-cultural studies in even in direct field research, is not a cross-cultural study of depression because by definition it will find what is “universal” and systematically miss what does not hit its tight parameters. The former is what is defined and therefore “seen” by a Western cultural model, the latter, which is not so defined and therefore not “seen”, raises far more interesting questions for cross-cultural research. It is precisely in the latter group that one would expect to find the most striking examples of the influence of culture on depression. Therefore, the kind of study Singer and the traditional transcultural psychiatric perspective believe to be “ideal” is systematically unable to study the influences of culture on depression. The data it is collecting are the wrong data for that purpose. Given its orientation such a study is bound to arrive at the conclusion Singer draws, it is a self-fulfilling prophecy.

Here we have evidence of a category fallacy, perhaps the most basic and certainly the most crucial error one can make in cross-cultural research. Having dispensed with indigenous illness categories because they are culture-specific, studies of this kind go on to superimpose their own cultural categories on some sample of deviant behavior in other cultures, as if their own illness categories were culture-free. This assumption simply cannot be made in comparative cross-cultural research as Fabrega has repeatedly shown [5-7]. Psychiatric categories are bound to the context of professional psychiatric theory and practice in the West. Psychiatry must learn from anthropology that culture does considerably more than shape illness as an experience; it shapes the way we conceive of illness [8, 9]. A true comparative cross-cultural science of illness must begin with this powerful anthropological insight. It must make a systematic analysis and comparison of the relevant illness categories prior to the study of illness phenomena.

Closely connected to the category fallacy is the traditional transcultural psychiatric preoccupation with disease as an entity, a thing to be “discovered” in pure form under the layers of cultural camouflage. This assumption results in the erroneous belief that deviance can be studied in different societies independent of specific cultural norms and local patterns of normative behavior. Both are problematic. The first assumption runs counter to our most developed contemporary conceptions of disease, which argue that disease—be it biological or psychological—is an explanatory model not a thing [10]. Thus, in comparing diseases one is always comparing explanations not entities. There can be no stripping away of layers of cultural accretion in order to isolate a culture-free entity. Culture shapes disease first by shaping our explanations of disease. This is additional support for the far reaching influence of the category fallacy. Most transcultural psychiatric research, because it ignores this issue, is no more than the application of Western psychiatric categories to non-Western societies. Although this type of research may hold importance for validating professional psychiatric constructs, by no means a trivial concern, we should not delude ourselves that it is studying disease in relation to culture or that it represents real cross-cultural comparisons.

For example the largest and most sophisticated study of this kind in the field of mental illness is the WHO supported International Pilot Study of Schizophrenia (IPSS) [11]. Although that study is an important advance in our understanding of schizophrenia, it starts from a category fallacy which significantly limits its value as a study of cultural influences on mental illness. Its strength comes from relying a narrowly defined syndrome affecting patients in nine separate cultural locations, but that is also its weakness. It is unable to systematically examine the impact of cultural factors on schizophrenia. Since its methodology has ruled out the chief cultural determinants. The homogeneous patient sample in each culture represents a fraction of all cases labeled as schizophrenia in those societies, and excludes all those carrying the most extensive cultural imprint. This is obviously an appropriate way to factor out a special class of psychotic disorders probably having a major genetic component and definitely distinct from other kinds of psychoses frequently labeled schizophrenia, not an inconsiderable achievement but it can tell us almost nothing about the relation of culture to either the group it includes or that much larger one it excludes.

The “ideal” cross-cultural study of schizophrenia or depression, on the other hand, would begin with detailed local phenomenological descriptions. Such phenomenological descriptions would enable us to compare indigenous and professional psychiatric explanations of these disorders along with the behaviors they interpret. They would elicit and compare symptom terms and illness labels independent of a unified framework. Translating between these local cultural accounts would be the basis for elaborating a comparative model and for making cross-cultural comparisons. The reverse of what usually occurs. These accounts could also be used to analyze the influence of culture on these disorders in each cultural site and later on to compare these influences between cultures. A final stage would be the testing at each site of specific hypotheses about the way culture influences these disorders, hypotheses which are generated by the phenomenological descriptions and the cross-cultural comparisons. Not only do we not possess such a study of schizophrenia or depression, but investigations of this kind represent a considerably different theoretical and research orientation from that which has become dominant in transcultural psychiatric studies [12, 13].

In summary, then, the chief failing of the “old transcultural psychiatry” is its total reliance on external, Western psychiatric categories which are applied by clinicians and epidemiologists as if they were “independent” of cultural bias, but which in fact are culturally specific categories. Moreover, they systematically disregard the key local influences on mental illness, beginning with the cultural shaping of disease models and the way we perceive, label, and evaluate deviant behavior. Other weaknesses of this approach are its preoccupation with the issue of cultural genesis rather than the more sophisticated and more pervasive question of cultural shaping of illness phenomena, its inability to get beyond the most superficial assessment of cultural variables, its greater interest in “universals” than “differences” and its remoteness from anthro-
political studies of normative behavior in the same cultural settings. Its inadequate conceptualization of disease as an entity, and its reliance on traditional epidemiological methods as virtually the only way to conduct cross-cultural studies.

THE NEW CROSS-CULTURAL PERSPECTIVE ON BEHAVIOR AND DEVIANCE: THE MERGING OF ANTHROPOLOGICAL AND PSYCHIATRIC RESEARCH

As a response to these salient weaknesses with the traditional approach, a "new cross-cultural psychiatry" is emerging as an interdisciplinary framework drawing off both anthropological and more recent psychiatric investigations of culture and illness. This inchoate field has several distinct components. First, there is a much more sophisticated use of psychiatric epidemiology. The work of Leighton, Lambo et al. [12] and most recently Carstairs and Kapur [13] confronts the issue of indigenous cultural categories, even if the working out of an ideal comparative epidemiological paradigm remains a distant goal, and makes use of anthropological data and ethnographic methods. On the theoretical level, Singer's predecessor at Hong Kong, the late P M Yap [14] explored the issues requiring integration into a comparative psychiatry. Interestingly, Yap's theoretical analysis and some of his own research on Chinese patients oppose Singer's conclusion, a point we shall return to in the following section.

The past decade has witnessed an increasing convergence of anthropological and cross-cultural psychiatric research on the ways culture influences the perception, classification, process of labelling, explanation, experience of symptoms, course, decisions regarding, and treatment of sickness [15-19]. One major advance has been the development of medical anthropological studies in which biologically-based disorders are studied [9, 15, 32]. This is providing us with a broader framework for understanding illness. It is also circumventing certain difficulties that continue to plague studies of cultural influences on behavioral deviance where cross-cultural markers are less certain or absent. Another major advance proceeds from the recognition that studies of illness in large-scale, literate non-Western societies offer more suitable comparisons with similar studies in the West than those performed in small-scale pre-literate societies [20, 21]. Closely related to this development is renewed interest in studying illness beliefs and behavior in the context of ethnic subgroups [22, 23] and popular (largely family-based) health care in the West [24, 25]. Finally, and perhaps most importantly, we are obtaining excellent ethnographies which focus on the relationship of normative behavior and deviance in non-Western societies [26-32]. These studies disclose the complex mechanisms by which culture affects emotions and psychopathology. Although we still lack systematic cross-cultural comparisons of depression, phenomenological descriptions from different cultures are becoming available [13, 26, 32-37] (see next section). A recent study by Rum et al. [38] is an example of a systematic comparison of psychopathology amongst matched patient groups in two distinct cultures (Japan and Taiwan) which attempts to relate differences to operationalized cultural variables. We can expect more of these studies in the future, including ones focused on depression.

In the following section I report such a study. Like the other investigations I have mentioned, it makes use of both clinical and ethnographic methods. I present these findings because they differ substantially from Singer's conclusion that they support a marked cross-cultural variation in the phenomenology of depression. Furthermore, they illuminate an essential theoretical distinction which has emerged from the "new cross-cultural psychiatry." That distinction I shall use to show why the merger of anthropological and psychiatric investigations carries us beyond a critique of Singer's conclusion toward a better appreciation of the relationship of culture and illness.

DEPRESSION AND SOMATIZATION IN CHINESE CULTURE

Psychiatrists in Chinese cultural areas have noted for some time the tendency of Chinese patients with mental disorders to present somatic complaints in place of psychological complaints [14, 35, 38, 42]. In one study, 70% of patients who were later documented to suffer from mental illness initially presented to the psychiatry clinic at the National Taiwan University Hospital with somatic complaints [35]. In a study carried out in the same clinic, my research assistants and I assembled a group of 25 patients with the depressive syndrome who presented consecutively to two of the daily psychiatric clinics. Twenty-two of these cases (88%) initially complained only of somatic complaints (i.e., they did not complain of dysphoric affect or report it when queried). During their subsequent treatment in the psychiatric clinic, ten patients (40%) never admitted to experiencing dysphoric affect. Seven of these patients (28%) rejected the idea that they were depressed even after they had been successfully treated (i.e., had experienced complete symptom relief) with anti-depressant medication.

Thus, 10 of 25 patients (40%) exhibited all the signs and symptoms of the depressive syndrome, and seven of those (28%) responded completely to specific treatment for depression, but none of them reported depressive affect or would accept the medical diagnosis that they were suffering from depression or mental illness. They looked upon their physical complaints as their "real" sickness, a physical sickness. Gaw [42], Tseng [35], and myself [9] have found much the same kind of phenomenological pattern amongst Chinese patients with depression in the U.S. The same has been reported for depressed patients in China prior to 1949 [43] and in Hong Kong [14, 44].

This finding contrasts sharply with depressed patients in the West. Amongst a parallel group of 25 patients with the depressive syndrome whom I assembled and studied in the same way at the Massachusetts General Hospital only one (4%) presented with somatic complaints in the absence of dysphoric affect, while four others (16%) reported somatic complaints along with dysphoric affect as their chief complaint.

Somaticization exists in the U.S. but to a much smaller degree than in Chinese cultural settings or
amongst Chinese patients in the U.S. Somatization appears to be more common in traditional societies, but perhaps not to the same extent it is found amongst Chinese, although this remains unproven. While Singer suggests somatization may relate more to socioeconomic class and educational level than to culture, there is some evidence that this is not the case [13, 45]. For example, in our study in Taiwan patients experiencing somatization represented the full range of socioeconomic classes and educational backgrounds, while amongst the somatizing patients in Boston, two were upper middle class college graduates. Somatization in the U.S. seems to be more common amongst ethnic minorities [45, 46]. Out of the five somatizers in our Boston study, three were Italian-Americans, one was a Jewish-American, and one was Black.

Our research findings enable us to appreciate how somatization functions in relation to depression and other mental illnesses amongst Chinese. In Taiwan, we found that about 50% of 100 patients we interviewed in the offices of indigenous healers suffered from somatization—making it the most common type of illness they treat [47]. Roughly the same degree of somatization can be found in the clinics of Western-style doctors in Taiwan [48].

Because mental illness is very highly stigmatized amongst Chinese—e.g. in Taiwan and Boston's Chinatown its presence in a family can lead to labeling that family's offspring unfit for marriage—it is not surprising that popular labels for mental illness cover only indisputably psychotic behavior and mental retardation. Minor psychiatric problems—depression, anxiety reactions, hysteria, psychophysiological reactions, etc. most commonly are labeled as medical illnesses. That is the secondary physical complaints accompanying the psychological disorders are labeled as medical problems, while the psychological issues are systematically left unlabeled. This provides them with a legitimated sick role, but a medical sick role. The medical sick role (as in the West) releases patients from responsibilities and obligations, sanctions failure, and affords them care. Since there is virtually no psychotherapy available in Taiwan and since indigenous healers and non-psychiatric Western-style doctors handle the vast majority of minor mental disorders, most psychiatric care for these problems is given under the guise of care for putative medical disorders. The most common medical sick role is shen-ching shuan jo (Mandarin neurasthenia). The popular belief holds this to be a physical disorder, but one said to include a range of psychological symptoms and to be stress-related. The Chinese characters which make up this disorder signify "neurological" and "weakness." But most behavior labeled neurasthenia would be diagnosed by a psychiatrist as minor mental illness, psychophysiological disorders, psychosocial problems, and interpersonal or family-related problems.

As Hsu has noted, Chinese informants and patients do not commonly reveal strong normal or dysphoric affects [49]. Cultural rules governing behavior prohibit such open expression [50]. Suppression of affect is common [51]. Patients frequently use physical complaints as a legitimated metaphor to indirectly express personal and interpersonal problems. Such terms function as semantic networks [36]. They link popular beliefs about body states and illness with psychosocial experiences and social relations. Such terms are often thoroughly psychophysiological. For example, in Mandarin a common word for depression is min. The character for this term is written with the radicle which represents the heart (classically and still popularly believed to be the seat of the emotions) inside a radicle representing a doorway. Most Chinese somatizers whom I have studied point to their chest when they use this term. They report a physical sensation of pressure on the chest or heart. But when they describe it by using min they mean both the physical sensation of something "pressing on" or "depressing into" their chest as well as its psychological concomitants—e.g. sadness. But they focus on the former as the chief problem. They might also relate this term to family tensions or social stresses. People interpret their depressive symptoms in these terms. They explain etiology, pathophysiology and course as well as symptoms and treatment by this popular cultural system of articulating and explaining illness. Family and friends use the same framework to interpret those symptoms. Other examples are suan (turbulence), a painful sensation common in Chinese patients with arthritis but also used to refer to a physical sensation felt in the chest believed to be affecting the heart, of people who are experiencing grief and actively mourning, and hou ch'i ta (big internal fire) which signifies a constellation of nonspecific upper gastrointestinal and oral complaints, but which also stands for certain emotional complaints. These symptom expressions have a major impact on the perception and labeling of symptoms, as well as on the experience and treatment of the disorders they manifest [47, 53].

Because they illustrate the striking difference in phenomenology between Chinese and American depressives, it is worth reviewing several brief case descriptions of somatization in Chinese patients. These cases are typical of many Chinese with depression I have studied and treated in Taiwan and Boston.

Case 1

Miss Liu is a 32-year-old unmarried Taiwanese accountant who presented to the Psychiatry Clinic at the National Taiwan University Hospital with headaches of several months duration. Besides headaches, she suffered from insomnia with early morning waking, easy fatigueability and loss of energy. She had been to Western- and Chinese-style doctors and had used self and family treatment without success. Her symptoms had begun shortly after the collapse of a love affair, one of several which her family had forced her to end over the years because of her disappointment and family problems. She now believed, apparently for the first time, that she would never marry owing to a combination of her age and basic disagreements with her family over what constituted a suitable husband.

During her first visit to the Psychiatry Clinic, Miss Liu denied repeatedly any deep or significant psychological problems. Slowly over a number of sessions,
she admitted feeling depressed and frustrated, and entertaining suicidal thoughts. Whenever queried in detail about her “bad feelings” (the general label she used to refer to them), she would quickly change the subject to her physical complaints or social problems. Beyond defining her feelings as depressed (mèn) she claimed she was unable to be more specific about them. but she admitted that they were intense and quite disturbing. Thinking about them made her feel much worse. She noted that talking about them “in a vague way” made them seem less severe, more distant, and less overwhelming. Minimizing or denying their existence made her feel better, as did talking about her family and somatic problems. She could see no value in talking about her feelings to a doctor, though she reported feeling better on those occasions when her feelings were most intense when she spoke to close girlfriends about them.

Miss Liu pointed out to us that the most effective method she had found for dealing with her “bad feelings” was to occupy herself completely with her work, and after she returned home to immediately eat and then go to sleep. That kept her from being preoccupied with her depressed mood falling asleep so early, however, resulted in her being unable to sleep throughout the entire night. instead, she would wake up quite early in the morning and then find herself unable to go back to sleep. “I was no longer tired.” But as soon as she awoke she found herself preoccupied with her dysphoric affect. At such times she noted she felt better if she could distract her mind by reading, working, or performing physical activity. Not infrequently headaches would occur at this time. When they were present, she felt totally preoccupied with them, and was unable to think about anything else. She reported, including her depressed feelings. Because of her unusual sleep cycle, Miss Liu often felt tired and sleepy in the late afternoon, so that by the time she returned home she was ready to eat and then immediately go to bed, thus perpetuating this behavioral cycle.

Case 2

Mr. Hung is a 60-yr-old retired Navy Captain from the China mainland. a widower now living alone in Taipei. He has suffered from the following constellation of symptoms over the past 2 years: weakness in all extremities, tremor of hands, unsteadiness of gait, heart palpitations, easily fatigued, profound weight loss, and insomnia. Full medical and neurological work-ups revealed no organic pathology on several occasions. Medical doctors told him he had neurasthenia. Since tranquilizers did not help and since Western-style medical doctors spent very little time talking to him about his problem and led him to believe there was nothing further they could do for his condition, Mr. Hung began visiting the clinic of a noted acupunctureist, a friend who had retired from the Navy. There over the last 6 months he has begun to feel much better with return of strength and appetite, increase in weight, improvement in gait, and greatly improved sleep pattern. He spends three full mornings each week in this Chinese-style doctor’s clinic. He receives a half hour of acupuncture therapy and some herb teas each visit, and spends the remainder of the morning sitting in the clinic talking with his friend and the patients who come there. He feels that his friend’s acupuncture has benefited him, but admits also that his friend has inspired confidence in him, helped him relax, and encouraged him to socialize—things that have been problems for him since the onset of his disorder.

Mr. Hung was in good health upon retiring from the Navy 3 years ago. However, over the next year he experienced severe financial reverses in his business ventures which left him without any income other than his very small government pension. These reverses destroyed both his savings and the plans for retirement he had made. He found himself deeply disturbed and ashamed. He felt that he had failed in life and had brought shame on himself and his family. He feared his friends would ridicule him if they knew his plight, and that he would lose “face.” He felt unable to express his sadness to anyone. He began to avoid his friends and his grown children. He experienced his depressive affect as a feeling of pressure on his head and chest. Whenever he felt sad or wished to cry he associated his psychological feelings with these somatic sensations. His depression came to mean not the psychological symptoms but the somatic ones.

“First the bad financial problem caused my depression on the heart and brain. (He demonstrates this with his hands as a physical pressure, a pressing on heart and brain.) Then that depression pressed further on me causing my nerves to become weak and also my heart to become weak. Now I take tonic and get acupuncture to make my heart and brain stronger.”

Mr. Hung would tell me he was depressed, but then describe that in somatic terms. If I asked him about his personal feelings he would not tell me anything other than that he was getting better. He would tell me repeatedly that his financial problems caused his sickness (which he believed to be a physical disorder), but if I asked him how this made him feel, tears would come to his eyes, which his facial muscles would strain to hold back, and he would look away for minutes at a time. He would tell me that these were things that were better not talked about, that he never talked about them with anyone, even with himself, that after all they were getting better, and then he would politely but firmly introduce another topic. Even after 4 months, when his depression had largely subsided, Mr. Hung refused to talk about what his feelings had been like. In fact, on one occasion he told me that he himself did not know what they were like since when they came to mind he felt his somatic symptoms greatly worsen and became preoccupied with the latter. He also admitted that he spent most of the time watching television, reading, collecting stamps, or playing card games in order to keep his “mind blank.” Keeping his mind blank seemed to him important because he felt his physical symptoms less at such times. Even at the time of my last visit, he could talk about his financial reverses in detail but could not say how they affected him beyond that they depressed his heart and brain, thereby hurting his nerves and bringing on all of his physical symptoms.

Case 3

Mr. W is a 33-yr-old Chinese male (Cantonese
Chinese doctor in New York's Chinatown, and he was also considering acupuncture treatment locally. The problem could not be helped by Western medicine, and he continued taking Chinese drugs throughout his illness. He finally accepted psychiatric care only after it was agreed that he would be given some kind of medication. During the course of his care, Mr. W never accepted the idea that he was suffering from a mental illness. He described his problem, as did his family, as due to "wind" (fiung) and "not enough blood" (m-kau huet).

Pertinent past history included the following. Mr. W was born into a family of educated farmers and teachers in a village in Kwantung Province. He and his family moved to Canton when he was a young child. His father died during the war with Japan, and Mr. W remembered recurrent feelings of grief and loneliness throughout his childhood and adolescence. At age 10 he accompanied his family to Hong Kong. 10 years later they moved to the U.S. Mr. W denied any family history of mental illness. He reported that his health problem began two years before when he returned to Hong Kong to find a wife. He acquired the "wind" disease he believes in retrospect, after having overindulged in sexual relations with prostitutes, which resulted in loss of huet-hei (blood and vital breath) causing him to suffer from "cold" (leiung) and "not enough blood." His symptoms worsened over the past 6 months, following his wife's second miscarriage (they have no children) and shortly after he had lost most of his savings in the stock market and in a failing restaurant business. However, he denied feeling depressed at that time, though he admitted being anxious, fearful, irritable, and worried about his financial situation. These feelings he also attributed to "not enough blood." Mr. W first began treating himself for his symptoms with traditional Chinese herbs and diet therapy. This involved both the use of tonics to "increase blood" (po-huet) and treatment with symbolically "hot" (ti) food to correct his underlying state of humoral imbalance. He did this only after seeking advice from his family and friends in Boston's Chinatown. They concurred that he was suffering from a "wind" and "cold" disorder. They prescribed other herbal medicines when he failed to improve. They suggested that he return to Hong Kong to consult traditional Chinese practitioners there. While the patient was seen at the Massachusetts General Hospital's medical clinic, he continued to use Chinese drugs and to seek out consultation and advice from friends, neighbors, and recognized "experts" in the local Chinese community. He was frequently told that his problem could not be helped by Western medicine. At the time of receiving psychiatric care, Mr. W was also planning to visit a well-known traditional Chinese doctor in New York's Chinatown, and he was also considering acupuncture treatment locally. He continued taking Chinese drugs throughout his illness, and never told his family or friends about receiving psychiatric care. He expressed gratitude, however, that the psychiatrist listened to his views about his problem and that he explained to him in detail psychiatric ideas about depression, etc. He remembered feeling badly about his care in the medical clinic where, after the lengthy work-up almost nothing was explained to him and no treatment was given. He had decided not to return to the clinic.

Mr. W responded to a course of anti-depressant medication with complete remission of all symptoms. He thanked the psychiatrist for his help, but confided that (1) he remained confident that he was not suffering from a mental illness, (2) talk therapy had not been of help, (3) anti-depressants perhaps were effective against "wind" disorders, and (4) since he had concurrently taken a number of traditional Chinese herbs it was uncertain what had been effective, and perhaps the combination of both traditional Chinese and Western drugs had been responsible for his cure.

Case 3 is typical of the use of indigenous Chinese cultural categories to pattern the perception and experience of depression. Although the content of the cultural label changes, this is the commonest pattern of somatization I encountered amongst Chinese. It is different from that found amongst non-Chinese somatizers just as the labels represent distinct cultural categories and experiences. Case 2, unlike Case 3, referred to himself as depressed, but by depression meant a somatic affect and physical disorder. Case 1, who is unusual in my experience, was willing to label herself depressed and talk about it, but was unable to clearly define her psychological complaint or to communicate in a psychological idiom. She is similar in this regard to non-Chinese somatizers with the depressive syndrome whom I have studied in Boston. All three cases demonstrate that somatization leads to specific treatment approaches, so that when we talk about cultural influence on the sickness we are also talking about its impact on treatment. It is misleading to separate the two. Taken together these cases illustrate a spectrum of somatization experiences of patients with the depressive syndrome which range from that exhibiting most extensive to that exhibiting least extensive cultural patterning. In the latter (Case 1) similarities with somatization of depression in other cultures are obvious, while in the former (Case 3) the patterning is so extensive that the sickness may appear unique (e.g. like so-called culture-bound disorders), yet it too is an instance of the depressive syndrome, as defined by the specific constellation of symptoms listed on p

CONCLUSION CULTURE, DISEASE AND ILLNESS

SOME THEORETICAL AND METHODOLOGICAL IMPLICATIONS FOR CROSS-CULTURAL RESEARCH

It can be flatly stated that the experience of most anthropological and psychiatric researchers working in Chinese culture supports the opposite of Singer's conclusion: depression has outstanding deviant features in Chinese society [14, 35, 40-42, 44, 47, 48]. I have tried to show how this discrepancy relates to certain limitations in the traditional transcultural psychiatric approach. Singer reviews and exemplifies as well as to the elaboration of a whole new generation
of anthropological clinical and epidemiological studies which I have termed the "new cross-cultural psychiatry". From what I have said it can be seen that cross-cultural research on behavior and disease is in process of changing theoretical and methodological paradigms new problem-frameworks and solution-frameworks are being developed and used. Examining one of these changes and its implications will be an appropriate way to conclude.

Recent analyses of cross-cultural medical and psychiatric research stress the importance of distinguishing two interrelated aspects of sickness disease and illness [15, 47, 52]. Disease can be thought of as malfunctioning or maladaptation of biological or psychological processes. Illness is the personal, interpersonal, and cultural reaction to disease. Although social and cultural factors may or may not influence the etiology, pathophysiology, and course of disease, they always influence illness. Illness is by definition a cultural construct. Disease may occur without illness, in which there simply is not sufficient time to generate an illness response. Illness may occur without disease, in which maladapting, and also perhaps in certain problems like the non-medical aspects of drug abuse and alcoholism that are made into illness problems for political, social, and historical reasons. But in most sickness, especially chronic sickness, disease and illness are parts of the same process. Disease and illness occur together and reciprocally influence each other. In diabetes and chronic physical impairment depression, schizophrenia, and so on, the illness reaction plays a large role in the form and meaning of the sickness. The illness response may strongly influence symptoms [53] and care [24, 25]. Just as there are disease problems so too there are illness problems. Whereas the former may respond to technological interventions, the latter frequently do not, and often require psychosocial issues to be attended to. Treatment of the former we can call cure, while treatment of the latter we can refer to as healing. Cross-cultural studies suggest most traditional healing systems provide both forms of treatment, whereas modern medical care provides principally the former. Patients appear to consider both essential [9, 47]. Evidence is accumulating that patient non-compliance and dissatisfaction with care is in part a function of the absence of healing in modern health care [9, 47, 52]. Discrepancies in doctor and patient evaluations of treatment efficacy seem to support this dichotomy [54] as does patient use of alternative forms of care [55].

The depressive syndrome as defined above, would appear to be a disease while the degree and form of somatization in Chinese culture would appear to reflect a major discrepancy between the way this disease is shaped into illness behavior in Chinese and Western cultures. Most of the research questions we have reviewed must be distinguished as to whether they pertain to disease or illness. Singer confuses these categories. But so does most of the work he reviews. The new cross-cultural approach to behavior and disease makes this separation so that it can study the relation of culture to both disease and illness. Yet it is already clear that the key questions facing cross-cultural studies in medicine and psychiatry lie on the illness side of the dichotomy. To focus only on the disease side is to strip the question of culture and depression of its chief significance. Yet this is a large failing in cross-cultural research as it is in medical research generally.

Biomedicine attends almost entirely to disease, and appears to be systematically blinded to the evaluation of illness. This holds enormous importance for health care throughout the world, and has deeply influenced medical research. Cross-cultural research in medicine and psychiatry heretofore has been under this seriously distorting influence [16, 56-58]. The major consequence of the "new cross-cultural" approach is its systematic attention to these questions which go to the heart of the relationship of culture to depression and illness in general [59].

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