



8-1-2002

Somatization vs. Psychologization of Emotional Distress: A Paradigmatic Example for Cultural Psychopathology

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Preparation of this paper was facilitated by a research grant from the Killam Foundation to the first author. The authors would like to thank Douglas Scoular for his comments on an earlier version of this manuscript.

Recommended Citation

Ryder, A. G., Yang, J., & Heine, S. J. (2002). Somatization vs. Psychologization of Emotional Distress: A Paradigmatic Example for Cultural Psychopathology. *Online Readings in Psychology and Culture, 10*(2). <https://doi.org/10.9707/2307-0919.1080>

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Abstract

This paper describes the developing area of *cultural psychopathology*, an interdisciplinary field of study focusing on the ways in which cultural factors contribute to the experience and expression of psychological distress. We begin by outlining two approaches, often competing, in order to provide a background to some of the issues that complicate the field. The main section of the paper is devoted to a discussion of depression in Chinese culture as an example of the types of questions that can be studied. Here, we start with a review of the epidemiological literature, suggesting low rates of depression in China, and move to the most commonly cited explanation, namely that Chinese individuals with depression present this distress in a physical way. Different explanations of this phenomenon, known as somatization, are explored and reconceptualized according to an increasingly important model for cross-cultural psychologists: the cultural constitution of the self. We close by discussing some of the contributions, both theoretical and methodological, that can be made by cross-cultural psychologists to researchers in cultural psychopathology.

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Introduction

Clinical psychology has been underrepresented in cross-cultural psychology, and vice versa, despite the abundance of important questions that lie at the intersection between these two fields. Examples of such issues include the extent to which disorders vary across different cultures, the importance of cultural specifics versus pan-cultural universals, and the underlying reasons why culture might influence, or fail to influence, a particular disorder (Ritsher, Ryder, Karasz, & Castille, 2002). Work in this area is a potentially fascinating arena for researchers interested in either culture or psychopathology; the fusion of these two domains can address many issues of both theoretical and applied significance while raising important questions about many of our dominant assumptions. The objective of this paper is thus to briefly survey some of the issues and methods used in the cultural psychopathology, within the context of one of the major outstanding issues in the field - somatization vs. psychologization of emotional distress.

Cultural psychopathology is an emerging interdisciplinary field taking as its subject the mutual influence of culture and mental disorder. As with cross-cultural psychology more generally, cultural psychopathology draws on adjacent disciplines dedicated to the study of culture, most notably anthropology, but also including such fields as history and economics, as well as several subdisciplines of experimental psychology. Complicating matters considerably, the psychopathology element involves another set of disciplines, primarily psychiatry, clinical psychology, and epidemiology. Other terms are sometimes employed for this field, including psychiatric anthropology and transcultural psychiatry; we have chosen *cultural psychopathology* in order to emphasize a topic area without implying that it is firmly situated within a single traditional academic discipline.

In the first part of this paper, we will outline two major competing paradigms for the study of culture's relationship to mental disorder, concluding with some possibilities for their reconciliation. Then, we will turn to a longstanding puzzle in the field, namely the repeatedly observed low rates of depression in Chinese cultures and the commonly provided explanation that these rates are due to a markedly different presentation of this disorder among the Chinese. It is our hope that this example, which will be discussed in some detail, will both inform the reader about this specific issue and provide a general framework for thinking about difficult issues in cultural psychopathology more generally. In so doing, we will repeatedly move back and forth between the evidence for a particular phenomenon and the various attempts to dig deeper into why these phenomena occur. We will conclude with some speculation on how the theories and methods of cross-cultural psychology might be used to make a unique - and, as yet, underutilized - contribution to the field.

Universalism vs. Relativism in Cultural Psychopathology

A central question for any study of culture is the extent to which culture is seen as a mask concealing underlying human universals or a fundamental source of human variation. In

cross-cultural psychology, following the work of Berry (1969), these positions are most often referred to as *etic* and *emic*, respectively. More recently, Berry, Poortinga, Segall, and Dasen (1992) described three ways of understanding how abnormal behavior interacts with culture, namely, the *absolutist* paradigm, the *universalist* paradigm, and the *relativist* paradigm. The first of these positions, corresponding to an extreme etic stance, proposes that abnormal behavior is identical in every culture. Today, however, this position is considered to be unrealistic - nearly all researchers and clinicians would agree that culture has at least some influence (Tanaka-Matsumi & Draguns, 1997). The remaining two perspectives take opposing positions on the extent of this influence. Those taking a universalist position emphasize underlying similarities across cultures, whereas those taking a relativist position counter that culture exerts a pervasive effect.

The Universalist Paradigm

The universalist approach to cultural psychopathology emphasizes the cross-cultural equivalency of diagnostic concepts and underlying processes. Most often, these concepts and processes are linked with the categories used in North America and Western Europe. Major Depressive Disorder, for example, is assumed to exist worldwide more or less as defined by established diagnostic criteria, such as those found in the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 1994). Although this position can, and has, been criticized for its Western bias, it is important to remember that the assumption of universality suggests that the culture in which constructs were originally derived makes little difference. If it is a given that symptoms and syndromes are manifestations of universal underlying processes, a scientifically based science of psychopathology would be expected to find the same general constructs regardless of where the research was originally carried out.

We should not caricature this perspective as being completely insensitive to the influence of culture. There is a growing appreciation of the ways in which culture can shape and modify the outward presentation of psychopathology. Thus, although universal processes remain central underlying features of disorder, culture influences the way in which it is expressed. Researchers are increasingly testing their models and their measures in different cultures, confirming reliability and validity before drawing conclusions. For example, Yang and colleagues (1999) recently studied personality traits in Chinese psychiatric patients using a carefully translated measure of the Five-Factor Model of personality. Before drawing firm conclusions from their research, they first ensured that the various subscales were reliable and were interrelated in a manner reflecting the underlying theoretical model of the instrument, namely, the Five Factor Model of Personality.

The Relativist Paradigm

In contrast to the universalist perspective, the relativist paradigm emphasizes a fundamental cultural role in psychopathology. Modern origins of this approach can be traced to Kleinman's (1977) paper on the *category fallacy*, or the tendency for cross-

cultural researchers to impose categories from their own culture - for example, clinical syndromes - on deviant behaviors observed in other cultures. Researchers taking this approach tend to focus on the role of culture in shaping classification systems, ways of experiencing distress, risk and protection factors influencing vulnerability to psychological problems, and beliefs among patients, healers, and community members about the causes and consequences of such problems (Marsella & Dash-Scheur, 1988).

Many of these investigators have questioned whether diagnostic systems and structured interviews developed in the West and using Western constructs can ever provide a universal framework (Draguns, 1996). According to these critics, it is far from certain that the same syndromes exist in the same form in other cultures. Moreover, individual symptoms may not necessarily present in the same way, with universal behavioral, emotional, or even physiological consequences. For example, there is evidence that fear presents quite differently in Hispanic cultures, in which *ataques de nervios* are characterized by, among other things, a feeling of rising heat. The clinician who is not aware of these symptoms will have a more difficult time establishing the presence of fear, particularly if he or she is relying on a standard interview lacking questions relevant to this way of experiencing fear.

In contrast, symptoms that are seemingly the same in different cultures may vary in terms of the underlying problems that they represent. For example, a characteristic such as fear of being spied upon, could be a marker for (a) understandable and non-pathological worry, during wartime or in a totalitarian state, (b) a simple phobia of unconcealed spaces, exaggerated but at least possible tenable in a society where such experiences are not unheard of, or (c) a psychotic delusion, in a relatively safe and sheltered small town. Here, again, the clinician or researcher may lack knowledge of the various cues that could be used to distinguish between these possibilities.

Chinese Depression as a Puzzle for Cultural Psychopathology

One of the first systematically reported cross-cultural differences in psychopathology was the apparent rarity of depression in Chinese cultures. Both Western and Chinese observers noted this tendency at least as far back as the 1970s, and proceed to study it using large-scale epidemiological methods by the early 1980s. Although the individual studies vary in both scope and quality, the composite picture they paint is one of a society relatively free of depression as it is defined in the West.

A survey of psychopathology cases was undertaken in 12 regions of China in 1982, and replicated in seven of these regions in 1993 (Zhang, Shen, & Li, 1998). Of the 19,223 people surveyed in 1993, only 16 reported having had a mood disorder at some point in their lives. Such findings are surprising, suggesting that the rate of depression in China is several hundred times lower than in North America. A similar study conducted by the World Health Organization reported that 2.3% of their sample developed depression over a one-year period, in contrast to the 10.3% rate found in the National Comorbidity Survey conducted in the United States. Several national community surveys conducted in Taiwan revealed similar low rates. The highest Taiwanese lifetime depression rate found by Hwu,

Yeh, and Chang (1989) was 1.7%, with a similar rate of 1.5% being identified by Weissman and her colleagues (1996). These findings can be contrasted with the 5.2% rate found in the United States (Robins et al., 1984), and rates as high as 19.0% found in surveys of other countries (Weissman et al., 1996).

Complicating the efforts to collect data comparable to that obtained in other countries is the possibility that Chinese depression might be present but take forms that are different from those emphasized in the West. In order to investigate this possibility, Chan and Lai (1993) conducted a hospital study of psychiatric patients in Hong Kong. Although approximately one third of these patients presented with symptoms associated with anxiety and depression, only about 10% had the collection of symptoms consistent with the classical picture of Western depression, dominated by depressed mood, feelings of worthlessness and guilt, and general psychomotor slowing. If the symptoms of these disorders are differently organized in Chinese patient or community populations, an imported Western syndrome-based approach may fail to detect individuals with significant psychopathology. In other words, survey respondents or clinical patients could be experiencing a number of symptoms, but not a sufficient number within a single Western diagnostic category.

This explanation, of course, begs the question of how Chinese symptom patterns might differ from those found in the West. One possibility was offered by Tseng and Hsu's (1970) observation that, "the Chinese are especially concerned with the body and find it relatively easy to somatize. They tend to manifest neurasthenic and hypochondriacal symptoms." (p. 11) By 'neurasthenic,' these authors are referring to a diagnostic concept, now defunct in North America, consisting of exhaustion, sleep problems, concentration difficulties, and other symptoms similar to the physical effects of depression and anxiety. Somatization, which refers to the presentation of psychological distress in primarily physical ways, is perhaps the most commonly discussed cross-cultural difference in depression. Not only has it been proposed as a possible explanation for the low rates of depression found in Chinese cultures (e.g. Parker, Cheah, & Roy, 2001), it has become a central problem for cultural psychopathology. This issue is complicated, however, by the various definitions of somatization in use and continued debate as to which definition best characterizes the Chinese experience of depression. The next section of this paper will review these definitions before moving on to the empirical evidence for somatization. In addition, the interested reader may refer to the appendix for three case vignettes, depicting different aspects of possible somatization and depression in Chinese patients.

The Phenomenon of Somatization

Definitions of Somatization

Many of the current confusions in the somatization literature can be linked to uncertainty and inconsistency in how the term 'somatization' is used (Simon, VonKorff, Piccinelli, Fullerton, & Ormel, 1999). Bridges and Goldberg (1985) categorized somatic presentations according to differences in three aspects of assessment: (a) initial symptom

presentation, primarily physical in somatizing patients; (b) subsequent symptom presentation, physical in some somatizing patients; and (c) symptom attribution, again physical in some somatizing patients. We will discuss these various definitions of somatization, and the assessment patterns characterizing them, in the rest of this section. As you read, note that following definitions begin with the most relativist and progress to the most universalist.

Somatization as Fundamental Experience

According to the first definition, somatization involves a fundamental difference in the way in which depressive symptoms are experienced. Here, the patient's actual experience predominantly involves the body, sometimes even to the exclusion of psychological symptoms. As a result, detailed evaluation and repeated contact will serve to flesh out the patient's clinical picture without revealing previously concealed psychological symptoms. Somatization is by and large a category according to this definition; some patients will clearly be somatizers, whereas others will fit the more traditional Western picture of depression. Following the Bridges and Goldberg (1985) system, clearly somatizing patients according to this definition would present predominantly physical symptoms at initial assessment, continue to present such a picture after detailed follow-up, and would attribute these symptoms to physical causes.

Somatization as a Focus on the Physical

The second definition of somatization pays less attention to whether or not the symptoms are taking place, focusing instead on their relative salience to the individual. In this conception, the somatic emphasis will be most apparent at the initial assessment, but psychological symptoms will be elicited following a thorough evaluation. Even still, however, the patient will continue to see the physical symptoms as being the most worthy of attention, although they may eventually endorse psychological as well as physical attributions (Bridges & Goldberg, 1985). Given that most, if not all, presentations of depression involve some somatic symptoms (e.g. APA, 1994), this definition adds the challenge of determining how high the ratio of physical to psychological symptoms has to be to identify a case of somatization. Thus, whereas the first definition clearly marks a somatization category, the second definition is better suited to a dimensional approach, particularly one in which two cultures are contrasted. Rather than stating that Chinese patients tend to be somatizers, we would claim that Chinese patients tend to somatize more than North American patients.

Somatization as a Strategy of Symptom Presentation

The third definition of somatization does not require any difference at all between physical and psychological symptoms as they are actually experienced by the patient. Instead, the term connotes a specific response style in which somatic symptoms are emphasized and psychological symptoms are concealed. The preference for physical symptom expression

is thought to lessen and eventually to vanish entirely after careful and structured assessment. After such an assessment, such patients would be expected to freely endorse psychological attributions for their difficulties.

Evidence for Somatization

Somatic symptom reporting

Since the publication of Kleinman's (1977) landmark report on somatization, several studies have found that Chinese individuals tend to complain of physical symptoms while avoiding psychiatric help. Much of this research has confirmed that Chinese patients predominantly report somatic features of depression. For example, Tseng (1975) reported that over 70% of psychiatric patients at a Taiwanese hospital had mostly physical symptoms. Tsoi (1985) similarly found that the most common symptom reported by individuals diagnosed with either depression or anxiety was 'general discomfort,' followed by 'pain,' 'insomnia,' and 'anxiety.' Unfortunately, these early studies did not include a Western comparison sample.

Such a sample was used by Parker, Cheah, and Roy (2001), who compared Malaysian Chinese and Euro-Australian depressed outpatients. Patients were asked to nominate a single symptom as their presenting complaint, and then to complete a self-report measure of cognitive and somatic symptoms. A somatic symptom was identified in 60% of Chinese patients as compared with 13% of Western patients. Inventory responses suggested that the Chinese respondents scored somewhat more highly on the somatic scale, but were particularly distinguished by their low scores on the cognitive scale. This study thus supports both the prediction of higher Chinese somatization and the parallel idea of Western psychologization.

Symptom structure

A different source of evidence for somatization can be found in studies investigating the symptom structure obtained from various depression inventories. Chang (1985) compared cross-culturally the dimensions of depression obtained from a questionnaire using a technique known as factor analysis. Whereas Euro-American students' responses were characterized primarily by cognitive and existential concerns, the strongest dimension for overseas Chinese students consisted of physical symptoms. Unfortunately, interpretation of these findings is hampered by the small samples used. A much larger community sample was used by Ying (1988), who studied the dimensional structure of the Center for Epidemiological Studies Depression scale (CES-D). The normative data, collected in a predominantly Euro-American sample, contained four dimensions - *Depressed Affect*, *Positive Affect*, *Somatic Symptoms*, and *Interpersonal Problems*. In contrast, Ying identified three dimensions in a Chinese sample, two mixing somatic symptoms with either depressed affect or interpersonal problems, and only positive affect replicating a dimension from the normative study.

Neurasthenia

Neurasthenia, or *shenjing shuairuo*, is a Chinese diagnostic category signifying a 'weakness of nerves,' widely accepted both by psychiatrists and other medical practitioners, as well as being accepted as a common illness by the general public. The official diagnostic system in China, the Chinese Classification of Mental Diseases, 2nd Edition - Revised (CCMD-2-R; Chinese Medical Association and Nanjing Medical University, 1995), has an official neurasthenia category. Five core symptom clusters are described, of which three must be present:

- (a) emotional disturbance manifested as troubled vexation or being easily aroused;
- (b) easily excited by activities, accompanied by many uncontrollable thought associations;
- (c) mental excitement or work leads to easy fatigue, including poor memory and concentration, ineffective thinking, inconsequential thoughts lingering in the mind, or head feeling unclear;
- (d) nervous pain associated with muscle tension, head feeling tight or swollen, pressure in the brain, or bodily pain; and
- (e) sleep disturbances.

The second symptom deserves some additional discussion, as it is often identified as the truly Chinese culture-bound symptom of the neurasthenia syndrome. The excitement can be caused by a wide range of otherwise normal activities, including work, study, conversation, movies, or television, and is experienced as unpleasant, particularly if it happens over a long time or cannot be controlled. Part of the excitement includes racing thoughts accompanied by frequent memories and associations, again experienced as unpleasant even if the thought content itself is not seen as being particularly negative (Shixie, 1989). This experience is particularly common when the individual is trying to sleep.

The second symptom aside, it is notable that many of these phenomena overlap, at least partially, with several DSM-IV symptoms of depression and anxiety. For example, sleep disruption is an official symptom of Major Depression, whereas easily getting fatigued is an official symptom of Generalized Anxiety Disorder. By the 1980s, as many as 80% of psychiatric outpatients in China were diagnosed as primarily neurasthenic (Kleinman, 1982), with up to 50% of such outpatients seeking treatment for self-diagnosed neurasthenia (Lin, 1989). These high rates, observed low rates of depression in Chinese samples, and the symptom overlap between depression and neurasthenia, led some researchers to suspect that the two disorders were one and the same.

Kleinman's (1982) study of neurasthenia in 1980 at a psychiatric hospital in Hunan province, China, served to unify thinking about this disorder with the somatization phenomenon. He used a structured interview keyed to DSM-III diagnostic criteria to assess 100 patients with a neurasthenia diagnosis, and concluded that 87% of them could be described as suffering from depression. Neurasthenia, he concluded, is a Chinese-

specific way of expressing depression resulting from somatization. Indeed, the great majority of the patients in this study presented predominantly with somatic concerns; of the chief complaints, headaches were present in 90%, insomnia in 78%, dizziness in 73%, and various pains in 49% of the patients. In contrast, depressed mood was given as a chief complaint in only 9% of cases. Again, however, there is a lack of Western comparison data with which to compare these results.

Somatization and Psychologization as Cultural Modes of Distress

Why Somatization? Why Psychologization?

Given that there seems to be sufficient evidence to conclude that somatization of some sort occurs in China, it may be tempting to cease our investigation and draw some conclusions. After all, our look at the literature on depression in Chinese culture has revealed a phenomenon, somatization, that we can keep in mind for future research and clinical work with this population. North American clinicians are indeed becoming increasingly aware of these cultural differences, and thus should be expected to pay attention to somatization when working with Chinese clients. There are reasons to suspect, however, that this termination of effort would be premature. At the most basic level, our attempts to address a long-standing question in the cultural psychopathology literature has left us with another question: *why* are Chinese individuals more likely to somatize? This problem is most likely to apply to theorists, particularly those with a primary interest in culture, who are not usually content to attribute a cross-cultural difference to some mysterious and unspecified attribute of culture.

In addition, we believe that clinical work itself will also benefit from a more careful investigation of this issue. Not only do we not know the underlying reasons behind somatization, we do not yet know which of the various definitions outlined previously best characterizes this phenomenon. Far from being a semantic quibble, the definition adopted will affect our expectations of how Chinese clients presenting somatic symptoms will change over treatment. For example, if Chinese depression really is a fundamentally separate phenomenon, clinicians will have to focus on new ways of understanding and treating this qualitatively different disorder. On the other hand, if Chinese patients present depression differently because they wish to avoid discussing psychological matters, then the clinician may well have to take a very different approach to the problem.

Somatization and Psychologization in the West

Another reason not to cease our investigation at this point involves evidence that somatization, however defined, is not solely a Chinese or an East Asian phenomenon not observed in the West. At the very least, somatic symptoms form a part of the experience of most depressed individuals; moreover, somatic presentations of distress have long been recognized in North America and Europe, and indeed have become the focus of renewed attention in recent years (Isaacs, Janca, & Orley, 1996; Kirmayer & Young, 1998). Bridges

and Goldberg (1985) estimated that over 30% of patients seen in primary care are actually presenting psychiatric problems in a primarily somatic way. Neurasthenia, too, is being increasingly studied outside of China, with one area of increased attention in recent years being the overlap between neurasthenia and chronic fatigue syndrome (CFS) in the West. Several observers have noted that the latter may be a Western-bound culture specific manifestation of the former (e.g. Abbey & Garfinkel, 1991). Not surprisingly, the overlap between CFS and depression has been controversial, especially given the observed tendency of many CFS patients to vigorously deny any psychosocial contribution to their condition.

Some researchers have proposed that somatization of depression is common enough worldwide that it should not be considered a Chinese-specific response style. Indeed, it may even be reasonable to instead characterize Western 'psychologization' as a culture-bound variable explaining observed cross-cultural differences (Kirmayer, 2001). The existence of such a possibility reminds us that observed cross-cultural differences are not necessarily solely attributable to idiosyncrasies of the 'other' culture. As in the Chinese case, somatization in the West is poorly understood. If somatization - and perhaps even psychologization - can occur in both cultures but are unevenly distributed, the next step must be to determine the cultural phenomena that can explain this difference. The consideration and evaluation of some possibilities is the focus of the rest of this section.

Theories of Chinese Somatization

Psychodynamic perspectives

As with so many other domains of psychopathology, the earliest attempts to understand somatization were done from a psychodynamic perspective. Here, somatization is defined as a lack of awareness that a physical symptom has a psychogenic cause (Parker et al., 2001). Expressing emotional problems through physical symptoms is seen as a way of avoiding anxiety-provoking content and is thus, from a culture-bound and Western point of view, often viewed as an immature defense (Draguns, 1996). This interpretation of somatization was also used by some of the first Chinese clinicians to write about the phenomenon, including the previously mentioned work by Tseng and Hsu (1970).

The mind-body distinction

Another explanation for somatization, again focusing on fundamental experience without the judgmental overtones of the psychodynamic perspective, involves cultural differences in the experience of mind and body. This theory proposes that certain cultures, including the Chinese, express emotions in ways that merge mind and body, rather than clearly separating the two (Kleinman, 1977; Tseng, 1975). Westerners, by contrast, are thought to focus on the mind, experienced as central to the self, while paying relatively less attention to physical experiences. Somatization would thus be defined as being a difference in attention to symptoms, and possibly even as a fundamental difference in experience. This idea has more recently been articulated by Ying, Lee, Tsai, Yeh, and Huang (2000),

commenting on Ying's (1988) finding of a Chinese-specific structure for the CES-D. Recall that the previous study had found a mixing of somatic and psychological symptoms. This mixing was interpreted as evidence of the centrality of somatic symptoms in Chinese depression, and was attributed to a reduced distinction between mind and body. As in other studies, such potential explanations were not themselves explored empirically; they will, however, be taken up again later in this paper.

Kleinman's conceptualization

Kleinman's (1977) earliest formulation of somatization incorporated the mind-body distinction just discussed, along with the ideas of emotional suppression and linguistic differences. Chinese individuals are thought to be reserved in expressing their feelings, avoiding open emotional displays in order to conceal weakness and maintain social harmony; this idea has growing empirical support (Markus & Kitayama, 1991a). The second concept, that Chinese individuals use bodily metaphors for emotional states due to lack of an adequate vocabulary in the Chinese language, has not been supported (Chang, 1985; Parker et al., 2001).

Kleinman (1986) later broadened the concept of somatization in the Chinese to include different ways that patients understand their symptoms, strategies for obtaining scarce health resources, and various communication symbols. However, much of the literature has preferred to either celebrate or criticize his original concept without adjusting to the ways in which his thinking has changed. His most recent formulation of somatization implicates the political upheaval of the Cultural Revolution and the swings between authoritarianism and liberalism that have followed. According to this model, somatization occurs because it is the most socially expedient way of communicating distress and dissatisfaction (Kleinman, 1997). Whereas his original formulation leaned towards more fundamental differences in the Chinese experience, more recent writings have instead emphasized particular strategies of symptom presentation.

Stigma

There is considerable work demonstrating that mental illnesses, particularly those with overt behavioral pathology, are particularly stigmatized in Chinese societies. Although there may in fact be a greater tolerance for symptoms when the illness can be kept within the family, Chinese families are particularly likely to attempt to shield the afflicted family member from the rest of the community (Ryder, Bean, & Dion, 2000). Many of the explanations that have been provided for the greater stigma of mental illness in Chinese culture, and the particular ways in which this stigma manifests itself, reflect the familial and interpersonal orientations of Chinese culture. Mental illness becomes a community issue as a result of the belief that a healthy mind contributes to social harmony. Family members are often seen as sharing the same problems that led to the individual developing a mental disorder, with serious implications for their interactions with the extrafamilial Chinese community.

In terms of the previously outlined definitions of somatization, avoidance of stigma points towards the most universalist possibility advanced - the actual experience of depression does not differ, but the individual is choosing a strategy of emphasizing physical symptoms. Unlike several of the other theories discussed, there exists at least some empirical investigation. Cheung (1995) reviewed a series of studies conducted with her colleagues demonstrating that Chinese individuals are much more likely to seek professional help if their symptoms are perceived as 'medical.' In a similar vein, neurasthenia is cited as an example of a diagnostic category that medicalizes and legitimates psychological problems, although this view is neither universally endorsed nor firmly established.

The Self as a Bridge Between Culture and Psychopathology

Cross-cultural comparisons of psychopathology have generally been limited to reports of differential symptom endorsement, with theoretical explanations being made on a post hoc basis rather than themselves being subjected to empirical verification (Cheung, 1995). A recent editorial in the *Journal of Cross-Cultural Psychology* noted that clinical contributions have the lowest rate of acceptance, linking this problem with the tendency for these papers to not be driven by theory (Smith, Harb, Lonner, & van de Vijver, 2001). In many ways, cultural psychopathology has been left behind by the theoretical advances made over the past two decades in culture research. The early 1980s saw the emergence of Hofstede's (1980) work on values across cultures, a system that, despite its flaws, encouraged cross-cultural researchers to examine and use systematically observed cultural variables to explain research findings. A decade later, Markus and Kitayama's (1991b) seminal paper on cultural differences in self not only further refined this work but also brought it into mainstream psychology.

The past ten years have seen a veritable explosion of culture research being published in traditional social psychology venues, much of it drawing inspiration from the Markus and Kitayama framework. This renewed interest in the self, with its new emphasis on culture, has allowed this concept to emerge as a vehicle for bringing the study of culture closer to the mainstream of psychological research. According to Markus and Kitayama (1991b), the *Independent Self* is characterized by a self-contained, individuated, separated self defined by clear boundaries from others, whereas the *Interdependent Self* is characterized by a relational, interconnected self with fluid boundaries. These two constructs correspond closely to two other concepts central to work in cross-cultural psychology, namely, individualism and collectivism. Although these ideas should be familiar to students of cross-cultural psychology, we will briefly outline them and their potential implications for cultural psychopathology. Most of Western psychology - and thus most of psychology - assumes a single, independent, model of the self wherein the individual is a separate and autonomous entity comprising distinct attributes which in turn cause behavior (Markus & Kitayama, 1991b). Here, the healthy self is defined as one that can maintain integrity and clear boundaries across diverse social environments, that can differentiate itself from significant others as part of the maturation process, and that can

successfully fend off challenge from others (Markus & Kitayama, 1994). In contrast, the view of the self that emerges in many non-Western cultures is fundamentally different, placing a much greater emphasis on the interconnectedness of selves with other selves. The major task of the interdependent self is not differentiation, but instead involves the maintenance of good relationships, fulfillment of roles, and accounting for the thoughts, emotions, and behaviors of other people (Markus & Kitayama, 1994). A growing body of emotion research suggests that this task is fulfilled, in large part, by an emphasis on restraint and emotional control. Interestingly, this view of the self, in general terms, has been said to characterize so many of the world's peoples that it may in fact be the independent self that is unusual, atypical, and exotic.

A tendency towards interpersonal sensitivity dependent, in part, on restraining and controlling the expression of emotion may help us to identify underlying reasons for the inhibition of psychological symptoms during a psychological assessment. For example, a longstanding tendency to deemphasize the importance of personal emotional states may lead to depressed patients with strong interdependent selves to selectively deemphasize psychological symptoms. Similarly, the desire for harmony maintenance may help to explain why interpersonally disruptive mental disorders are particularly stigmatized, a notion is consistent with previous work on stigma in Chinese culture (e.g. Ryder et al., 2000).

Dualism vs. Holism

In our previous discussion of proposed theories for somatization, mention was made of the mind-body distinction as a possible root cause. Here, instead of emphasizing the separateness vs. connectedness of self and other, we are considering the separateness of the self in the mind as opposed to its connection with the body. In mainstream Western culture, body and mind are experienced dualistically, clearly separable and distinguishable. Moreover, the mind is considered to be the ultimate seat of the self. In Western medicine, for example, physical and mental illness are differentiated, with the classification of depression as a mood disorder accompanied by somatic symptoms representing a mind-body dichotomy (Jenkins, 1994). Similarly, the notion of somatization suggests that the psychological precedes the physical, rather than the two concurrently and mutually reinforcing one another (Cheung, 1995).

In contrast, Chinese medicine - and, perhaps, culture more generally - views mind and body as being integrated with one another as well as with social context (Wu, 1982). Here, psychological, physical, and social factors combine to contribute to the Chinese sense of self as well as to the development of specific illnesses, and are viewed as being inseparable (Cheung, 1995). This conceptualization of self is often used as an underpinning for more focused theories of East-West differences, including the independent and interdependent selves (e.g. Markus & Kitayama, 1991b). Unfortunately, direct investigation of cultural differences in the experience of mind and body is rare.

Use of this distinction as an explanation of Chinese somatization has fallen out of favour in recent years, in large part because the notion of poor differentiation between

mind and body is considered demeaning. It is not necessary to assume, however, that such an experience of mind and body is necessarily inferior. By changing our language, we can characterize Chinese individuals as having a well-integrated experience of mind and body, with the Western self being comparatively isolated from the body. Indeed, many psychologists and other scientists now believe that the Western assumption of mind-body dualism is inaccurate and is serving to obscure the numerous interconnections between the two.

Use of Self-Concept Variables as Research Tools

Cheung (1995) has rightly criticized the use of self-concept variables, along with many other proposed explanations for somatization, as explanations after the fact. Data is collected first and interpretations are offered later, often based on gross cultural generalizations. It is here that cross-cultural psychology can make a potentially important contribution to the methods of cultural psychopathology, using the strategy of "unpacking culture." This technique will be briefly discussed in the context of our discussion on somatization, but could be applied to a wide range of potential explanatory variables in the field. One of the important implications of recent work on the self has been to appreciate the role of both individual and cultural levels of analysis for psychological variables. To take a simple example, one can discuss national differences in wealth while at the same time remembering that individual wealth may vary widely in both countries. In the same way, rather than merely identifying the predominant self-concept of particular cultures, persons within cultures are also seen to vary along dimensions representing relevant aspects of the self-concept (Singelis, 1994). There is thus room to identify, for example, Chinese individuals with a strong independent self or American respondents with a tightly integrated sense of mind and body.

Simultaneous consideration of both cultural and individual levels can allow us to strengthen our explanations by "unpacking culture," showing that our explanatory variables explain differences both within and across cultures (Heine, Lehman, Peng, & Greenholtz, 2002). Returning to our example of wealth, we might study levels of happiness in two countries and find that the happier country also happens to be the wealthier country. Concluding that differences in happiness are attributable to differences in wealth is premature, however, as there are numerous other variables that might differ between these two countries. If, however, wealth and happiness are also shown to be positively associated within each country, we can be more confident in concluding that wealth is a plausible explanation for the observed differences in happiness.

Similarly, we can best explore the relation between self and somatization by declaring our hypotheses on an a priori basis and then investigating this relation at both levels of analyses. If independent self is associated with psychologization and interdependent self is associated with somatization in both cultures, then we can move closer to understanding why these cultures differ. Moreover, we can also begin to hypothesize why certain people are exceptions to the general rule, showing for example

that depressed Chinese individuals with a strong independent self are just as likely to present psychological symptoms as the average depressed North American individual.

Concluding Remarks

We began our discussion of cultural psychopathology with a brief description of the field itself, noting the potential for cross-cultural psychology to make a valuable contribution. Then, after reviewing the main competing paradigms in this area, we focused on a particular challenge - understanding Chinese and Western differences in depression and somatization - that has become almost emblematic of the field as a whole. In tracing our attempts to address this issue, however, it may have become increasingly apparent that many of the possible explanations are, quite simply, possibilities. Here, the pace of theory has far outstripped the pace of empirical research. Even our own suggestion, that of looking closer at the self-concept, awaits empirical investigation.

It is our hope, however, that proposing an explanatory variable with considerable support in the cross-cultural literature, together with a research orientation towards explaining and 'unpacking' these cultural explanations, will establish a template for future studies. And although our focus has been on Chinese culture and the somatization phenomenon, the logic of this approach can, we believe, be applied to a number of different puzzles still existing for cultural psychopathology. The field is made more complicated both by its subject matter and by the many viewpoints and methods provided by the various academic disciplines involved. Nevertheless, it is ultimately stronger for this complexity, and as cultural psychopathology moves ahead in subjecting these difficult questions to careful analysis, this field will require the contributions of all of these perspectives. Within this difficult and fascinating field, we are confident that cross-cultural psychologists have a critical role to play.

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Appendix

Case 1: Jin Liu

Jin Liu is a 24-year old male who presented to the second author at the psychological clinic of Hunan Normal Medical University in Changsha, China. He is the son of chemical engineers, and works as a communication technician. At assessment he appeared to be emotionally constrained and physically tense. His initial complaints focused on tension, stiffness, and numbness of his facial muscles, and he stated that other physicians had been unable to help him with these physical problems. Although at that time he did admit to distress surrounding these specific symptoms, he denied depressed mood and other negative emotions.

After several weeks of psychotherapy, however, Mr. Liu admitted to considerable emotional distress, including depressed mood, acute shame, and a sense of worthlessness, noting that he had never mentioned these feelings to anyone before. Most of this distress is related to hypersensitivity regarding interpersonal relationships, with significant interference in his ability to function both socially and professionally. He stated that he had no idea how to get along with other people, despite having a strong desire to maintain social harmony: "In group situations, I always have the feeling that I'm being overlooked by others...I assume other people think me stupid...I need to be affiliated with others, as if I only exist if I am accepted."

Mr. Liu's original somatic symptoms, involving facial discomfort, may be explainable in terms of this anxiety. He expressed a fear of being looked at by others, with a belief that other people would judge him on the basis of his facial expressions. As a result, he goes to considerable effort to control his expression so as not to give anything away. At the same time, ironically, he also stated that he worries that others notice his facial stiffness and end up feeling uneasy or uncomfortable themselves.

Case 2: Betsy Fung

Betsy Fung is a 30-year old female who presented to the first author at the psychological clinic of the University of British Columbia in Vancouver, Canada. She was born in Hong Kong, and moved to Canada 7 years ago. Currently, she is working at a banquet hall owned by her uncle. At assessment she appeared to be quiet and withdrawn, although she became increasingly engaged with the process as it progressed. Her initial complaints focused on headaches, muscle pain, and problems with digestion. She admitted to some anxiety, which she characterized as, "normal for everyone," and denied depressed mood; her stated reason for going to a psychology clinic was to get, "some practical skills for dealing with public speaking anxiety."

After several weeks of therapy focusing on social phobia, Ms Fung described additional physical symptoms, consistent with depression, that had been causing considerably more impairment than had been described at the initial assessment. For example, she stated that she has been losing weight, not sleeping well, feels tired, "all the time," and has been having difficulties making everyday decisions. She added that, as a result, she has been unable to work for one month and that her family is growing frustrated. These symptoms were attributed to a virus or other illness.

During the tenth session, Ms Fung began to describe feelings of frustration and loneliness, centering around homesickness for Hong Kong and a growing sense of estrangement from others. She expressed anger for being forced to emigrate in order to follow her husband. Although she still maintained that her present difficulties were largely due to illness, she agreed that acculturation stress might be, "making me more vulnerable." Unfortunately, after our discussion of possible psychological elements to her distress, she missed two consecutive sessions and could no longer be reached. Treatment was thus discontinued.

Case 3: Qiang Tang

Qiang Tang is a 19-year old male who presented to the second author at the psychological clinic of Hunan Normal Medical University in Changsha, China. He is currently enrolled at a local university. At assessment he appeared to be somewhat nervous and distracted, and his posture was slumped. His initial complaints focused on insomnia, lack of energy, concentration difficulties, and some anxiety. He denied sad mood and other emotional symptoms of depression.

After a more thorough assessment, additional physical complaints emerged along with some interpersonal concerns. Mr. Tang described a sleeping pattern, consistent with neurasthenia, of racing thoughts interfering with sleep at night coupled with fatigue and sluggish thinking during the day. In addition, he added that he often felt that the skin on his head was very tight, to the point where sometimes his head would feel as if it were, "exploding." When describing his interactions with others, he stated that he tends to get very nervous and excited, and becomes very aware of physical sensations, such as pounding heart and feeling that his, "whole body is falling apart."

By the end of treatment, some discussion centered around more psychological or emotional issues, suggesting the possibility of depression. Nevertheless, Mr. Tang remained much more comfortable discussing his physical symptoms and interpersonal difficulties, and was more willing to accept physical explanations for his current difficulties.

Questions for Discussion

1. The first section of this paper describes three paradigms for cultural psychology, as described by John Berry and colleagues (1992). To what extent do the various explanations for somatization/psychologization fit into these categories?
2. The authors characterize the current state of knowledge about depression among the Chinese as a "puzzle." Why?
3. What is the potential role of neurasthenia, a supposedly outdated Western clinical construct, in our understanding of depression among the Chinese?
4. Why might it be important to consider Western psychologization in addition to Chinese somatization?
5. A particular study might involve various methods of assessment, for example, an open-ended reporting of symptoms, a questionnaire tapping particular symptoms, a structured interview, or clinician rating scales after completion of psychotherapy. It is possible that detection of Chinese somatization might occur with all, some, or none of these methods. Describe the pattern of findings you might expect to find in support of each explanation for Chinese somatization presented in the paper.
6. What problems might arise from assuming that the independent model of self is a universal phenomenon?
7. The paper implies that there might be, "room to identify, for example, Chinese individuals with a strong independent self or American respondents with a tightly integrated sense of mind and body." How might such individuals present distress? How might consideration of such individuals help us to 'unpackage' culture?
8. Think about your knowledge of cross-cultural psychology in a domain separate from the 'self.' How might this aspect of culture make a contribution to cultural psychopathology?