# Somatisation among Asian Refugees and Immigrants as a Culturally-shaped Illness Behaviour

S I H Hsu,* MD, PhD

**Abstract**

*Epidemiological studies indicate a high prevalence of major depression and anxiety disorder (including post-traumatic stress disorder) among Asian refugees and immigrants living in North America. Yet there exists an alarming underutilisation of mental health services and underdiagnosis of psychiatric illness in this rapidly growing minority group.*

*In order to investigate a culturally-derived basis for these observations, a critical review was conducted on descriptive epidemiologic, sociologic, and anthropologic studies of psychiatric illness among Asians and Asian refugees and immigrants reported in the general psychiatric and trans-cultural psychiatric literature of the past forty years.*

*Studies examining the mode of illness presentation among Asian refugees seeking medical care suggest a marked tendency to articulate somatic rather than affective complaints when serious underlying psychiatric conditions exist. In this context, somatisation among Asian refugees and immigrants may reflect culturally-shaped beliefs regarding notions of disease aetiology and treatment as well as what is deemed culturally-appropriate help-seeking behaviour during illness.*

*Misdiagnosis and underdiagnosis of psychiatric illness in this and other minority populations can be minimised by establishing pluralistic norms and multidimensional criteria which take into account the ethnically diverse manifestations of illness behaviour encountered increasingly in Western primary care and psychiatry clinics.*

*Ann Acad Med Singapore 1999;* **28:841-5**

*Key words: Anxiety disorder, Major depression, Mental illness, Transcultural psychiatry*

## Introduction

During the past two decades, close to one million Southeast Asian refugees of war have resettled in North America. Together with the already significant Asian immigrant population, they represent one of the fastest growing minority groups in the United States. Given the harrowing experiences of war, torture, forced migration, the loss of significant relationships, and resettlement in a socioculturally alien host country, epidemiologists have been uniformly distressed by the finding of underutilisation of mental health services by Southeast Asian refugees and Asian-Americans in general.[1,2] In agreement with results from previous studies on symptom presentation among Chinese, investigators have reported a marked tendency among Asian refugees seeking medical care to present with multiple somatic rather than psychological complaints when serious underlying psychiatric conditions existed. These reports suggest that the process of somatisation among individuals in these groups does not necessarily reflect the psychiatric disorder of somatisation. This distinction has important prognostic implications, since somatisation disorder has limited therapeutic potential. In this context and throughout the following discussion, the term "somatisation" will be used to denote the tendency of a patient to present with physical symptoms in the absence of demonstrable physical findings or known physiologic mechanisms that might account for the symptoms. The DSM-IV diagnosis of "somatisation disorder," on the other hand, is made when somatisation involves a multitude of physical symptoms referable to the gastrointestinal tract, nervous system, cardiopulmonary system, or genito-urinary system, usually in young women and persisting for several years." The following review critically evaluates the literature on somatisation among Asian refugees and immigrants. The findings support a need to 1) engender in health care providers a heightened awareness of somatisation as a culturally-shaped illness behaviour among Asian refugees and immigrants with major depression or anxiety disorder (for definitions see reference 3); and to 2) emphasise the clinical significance of understanding a patient's cul-

* *Resident in Internal Medicine*
*Medical Services, Massachusetts General Hospital*
*Boston, Massachusetts, USA*
*Address for Reprints: Dr Stephen I-Hong Hsu, Department of Medicine, National University Hospital, 5 Lower Kent Ridge Road, Singapore 119074.*
*E-mail: mdchsus@nus.edu.sg*

tural context in the practise of primary care medicine and psychiatry.

**Depression, Anxiety, and Somatisation Among Asian Refugees in North America**

Both clinical and field observations of the mental health status of Vietnamese,[4,5] Hmong-Laotian,[6-8] Cambodian,' and Amerasian[10] refugee communities established in the United States and Canada have indicated a high prevalence of both major depression and anxiety disorder (including post-traumatic stress disorder). In one fairly representative study, a high prevalence of depression (52%) and a high level of clinical underdiagnosis (56%) were found in Vietnamese patients at a community primary care clinic.[4] Astonishingly, 95% of these patients presented with physical symptoms, while none presented with psychological complaints. Dysphoric affect was confirmed by the patients only if the clinician questioned them. Interviews conducted both in the clinic and during home interviews indicated that although Vietnamese were not necessarily reticent about their emotional reactions towards their experiences of loss and sociocultural displacement, these patients were generally doubtful about any relationship between emotional distress and any psychiatric or somatic symptoms.[5]

**Somatisation versus Psychologisation**

Studies conducted among Chinese psychiatric patients have suggested that affective symptoms were presented less frequently than neurasthenic, hypochondriacal and psychosomatic symptoms. Tseng[11] has pointed out that one of the most distinctive features about Chinese neurotics is the predominance of somatic complaints rather than psychological ones. For example, Tseng[12] and Kleinman[13] give extensive case examples of individuals diagnosed as depressive, but who do not readily articulate affective complaints. Indeed Yap,[14] Leff,[15] and others have suggested that somatisation and depression may be mutually exclusive ways of expressing psychosocial distress among Asians.

A number of sociocultural and anthropological explanations have been offered to account for the reported marked tendency of Asians to "somatise" psychiatric illness. These include the cultural norm of suppressing affect,[16] the lack of a semantic framework for conceptualising or expressing affect,[12] traditional Chinese medical concepts which integrate the functions of mind and body in relations to health," social stigma and the role of guilt and shame in psychological repression/suppression[12,17] and socioeconomic or educational differences.[4,7,8,18]

Implicit in the first two explanations above is the suggestion that the utilisation of somatic responses to communicate distress is characteristic of an underdeveloped ability to communicate emotions by verbal symbols. A superficial impression is formed that Asians are not "psychologically-minded." It may be argued, on the other hand, that middle-class educated urban Americans, the "Westerners" that Kleinman used to define his norm, are more unusual in cross-cultural terms in their tendency to psychologise and to separate the mind from the body.[19] Indeed, Kirmayer[20] has identified "psychologisation"—the emphasis on cognition, emotion, and related structures, events, processes, or attitudes as the critical parameters of psychopathology-as a philosophical bias which exists in Western biomedical psychiatry.[21-23] While the DSM-IV[3] criteria for major depressive disorder include both psychological (affective) and somatic (neurovegetative) components, the absolute minimal requirement for either "depressed mood" or "loss of interest or pleasure" betrays the "psychological" bias of Western psychiatric theory and practice. In contrast, the presence of somatic complaints rather than anxious mood accurately identified Vietnamese refugees with post-traumatic stress disorder.[24] Indeed, numerous ethnographic studies have described a relative lack of psychological explanations in the ethnomedical views of many non-Western cultures, as well as in those of certain socioeconomically depressed and less educated groups within Western countries.[22]

Whereas discourse on the platonic notion of the dichotomy between mind and body has been and continues to be a predominant theme in the history of Western philosophy,[25] the theoretical system of traditional Chinese medicine does not distinguish between mind and body, nor between the body (microcosm) and nature (macrocosm).[11] Moreover, Chinese medicine itself, as medicine, is characterised by an organ-oriented view of bodily function (including psychological function), and an herb-oriented treatment approach. Thus the expression of psychological distress in predominantly somatic terms may reflect, at least in part, cultural beliefs regarding notions of disease aetiology and treatment. Indeed, Mollica et al[26] have suggested that the Western clinician cannot understand the Indochinese refugee's trauma story without first becoming acquainted with the meanings of the terms "torture" and "trauma" in Indochinese culture. The Cambodian term "torture" is closely associated with the Buddhist concepts of karma and reincarnation-the belief that one's present life circumstances are determined by one's deeds in previous lives. This encourages a sense of fatalism and acceptance of the suffering inflicted during torture and may inhibit the patient from recounting the "trauma story" in the clinical setting, since its relationship to medical complaints is not obvious to the victim. This may explain the observed lack of receptiveness to psychodynamic psychotherapeutic approaches by Indochinese trauma victims, as

compared to South American victims who come from cultures in which psychoanalytic psychotherapy is accepted and widely practised.[27]

The tendency toward somatisation observed among Asian patients may not, however, exclude psychological awareness. A number of recent studies have challenged the notion that Asians are psychologically "naive," suggesting instead that somatisation and depressive symptoms may be alternative but not mutually exclusive ways of expressing distress.[6,19,28,29] In their study on Chinese depressives in general practice, Cheung et al[30] reported that many patients were aware of the psychological features in their emotional disturbances even though they tended to express these disturbances in somatic terms in the context of medical help-seeking. Indeed, the authors explained their results by distinguishing between the expression mode and the recognition mode of somatisation, such that the expression of psychological features may depend on what are culturally deemed as appropriate situations and occasions. Tseng[11] has observed that in traditional Asian cultures in which major mental illnesses are highly stigmatised, somatic illness is an effective and legitimate excuse to request rest and to mobilise intrafamilial and community support, while emotional problems are viewed as trivial personal issues and not worthy of attention. Indeed, it is reasonable to suspect that somatisation may be a common mode of help-seeking behaviour among Asian refugees who have experienced torture and war trauma, regardless of whether underlying psychiatric disease exists.

Discrepancies between the conclusions drawn from Cheung's studies and those of previous reports on somatisation may reflect differences in methodology. The subjects in Cheung's studies were questioned on different aspects of their lives without direct reference to psychiatric illness.[30] This approach may have facilitated more open discussion of psychological issues by creating a social context free of stigma. Previous conclusions on somatisation among Chinese were also based primarily on patients' responses to illness, rather than on detailed, structured interviews. Thus, the high prevalence of somatisation reported for Asians may actually reflect clinical misinterpretation of patients' discomfort reporting (somatic complaint) as disease manifestation (somatic symptom), whereas in fact these two do not necessarily coincide.[31] Furthermore, both Cheung[19,30] and Cheng[31] recognised the importance of avoiding the bias of social selection factors inherent in basing studies on psychiatric intakes, since the high apparent frequency of patients with somatic complaints might be due to their decision to seek medical help rather than reflect a major feature of psychiatric illness in the general Asian population. Taken together, these studies strongly dispute the contention that Chinese in general tend to deny their emotions,[19,30] and also confirm that somatisation among Asians more likely reflects culturally-shaped illness behaviour (that is, how an individual in a given sociocultural milieu interprets and reacts to his illness) rather than a true clinical entity such as somatisation disorder, as defined by DSM-IV.[3]

**Towards Effective and Responsive Asian Mental Health Service**

Epidemiological studies report that Asian-Americans suffer significant psychiatric morbidity as a consequence of their underutilisation of mental health services, as well as the unresponsiveness of that service.[1,2] Recent years have seen a significant increase in the prevalence of cases requiring chemotherapeutic intervention rather than psychotherapy alone, which may reflect an increase in the number of serious psychiatric intakes at the few existing community mental health clinics that target Asian refugees and immigrants. Stereotyped ideas about Asians as generally "cheerful, poised, secure, unanxious, and successful," are challenged by both the significant rate of attempted and completed suicides and the rising incidence of alcoholism and substance abuse among Asian refugees and immigrants in North America.[9,32,33] In light of the effective treatments available for the major psychiatric disorders, the limited therapeutic potential and inordinate cost incurred by the health care delivery system in treating patients given the diagnosis of somatisation disorder, and the high risk of iatrogenic harm to such patients due to unnecessary medical procedures,[34] proper diagnosis of underlying psychiatric illness in Asian-Americans is essential.

Cheung's notion of the "expression mode" of somatisation also implies the need to ask patients directly about their psychological symptoms. Here, structured clinical interviews and computerised diagnoses based on standardised and culturally relevant psychological instruments may prove highly reliable.[28] This approach may help to avoid the bias of clinicians who may overemphasise the content of certain questions (depression and somatisation) in formulating clinical diagnoses. However, misdiagnosis and underdiagnosis will continue to confound the efforts of service providers until research priorities begin to focus on the establishment of pluralistic norms and multidimensional criteria for Asian-American and other minority groups. DSM-IV criteria for psychiatric disorders, as they currently stand, do not adequately address the ethnically diverse and culturally-shaped manifestations of illness behaviour increasingly encountered in Western primary care and psychiatry clinics.

Silove et al[35] have correctly pointed out that there are risks in both exaggerating or underemphasising the influence of culture in psychotherapy. Mental health services should ideally account for individual contex-

tual factors, culture being one such factor. Thus, even while Asian cultures in general tend to respect deference to authority, strong intrafamilial ties, and communal responsibilities, individual Asian patients may display a wide range of acculturation to Western society and therefore various degrees of receptiveness to Western psychotherapeutic approaches. Indeed, traditional Indochinese concepts of healing in which medical history taking and lengthy discussions about symptoms are minimised and medication is almost always given in response to a patient's symptoms, share more in common with the Western medical model of psychiatry and psychopharmacotherapy in which the focus is on the active and directive role of the psychiatrist in relieving symptoms, than with the psychotherapeutic models of treatment in which personal disclosure and verbal testimony play a key role.[27] The use of psychotropic medications, particularly tricyclic antidepressants, has been shown to play an effective role in achieving symptom relief in this population.[36]

Although traditional Western psychotherapeutic approaches may appropriately constitute the mainstay of services provided to some Asian refugee or immigrant clients, the unique cultural characteristics of Asians in general warrant a mental health service delivery model and therapeutic techniques that are different from those designed within the framework of Western cultures. Hong[37] has suggested that a general family practitioner approach may be particularly suitable for Asians, since it emphasises the role of the family while helping to minimise the client's inhibition against seeking mental health services. Others have pointed out that psychological traits associated with Asian culture-respect for authority, filial piety, and shame-which are often seen as interfering with the therapeutic process because they inhibit self-disclosure and open communication with authority figures such as therapists, may in fact have positive and facilitative functions.[38,39] Shame, for example, may reflect an individual's sense of social responsibility rather than self-debasement. Likewise, respect for authority figures may reflect an individual's successful internalisation of superego ideals and social reciprocity rather than passivity and dependency needs. The challenge is to find ways in which these psychological traits may be used to constructive advantage in the establishment of the therapeutic alliance between physician and patient.

Finally, issues of cultural adaptation will invariably find their way into the therapist's office. For example, many first-generation Asian-Americans, particularly adolescents, experience considerable confusion associated with the difficult task of adjusting to life at the interface of two quite disparate cultures. On the one hand, their elders expect them to incorporate traditional values into their lives and continue to perpetuate their cultural identity and belief systems. On the other hand, many of those traditional values conflict with Western notions of education, material success, and personal growth. The approach of the therapist must be one of helping the individual to successfully blend the positive elements of the splendid bicultural offerings inherent in the Asian-American experience, so that successful social and occupational functioning is not attained at the expense of the loss of ethnic identity and intrafamilial support.

**Acknowledgements**

The author would like to thank Theresa Kwan of the Chinatown Family Consultation Center (New York, New York, USA) for helpful discussions, and Drs Van Nguyen, John Stoeckle, Ravi Thadhani and John Corwin for their critical review of this manuscript.

REFERENCES

1. Sue S, McKinney H. Asian Americans in the community mental health care system. Am J Orthopsychiatry 1975; 45:111-18.
2. Sue S. Community mental health services to minority groups. Some optimism, some pessimism. Am Psychol 1977; 32:616-24.
3. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 4th ed. Washington, DC: American Psychiatric Association, 1994.
4. Lin E H B, Ihle L J, Tazuma L. Depression among Vietnamese refugees in a primary care clinic. Am J Psychiatry 1985; 78:41-4.
5. Lin K M, Masuda M, Tazuma L. Adaptational problems of Vietnamese refugees. Part III. Case studies in clinic and field: Adaptive and maladaptive. Psychiatr J Univ Ottawa 1982; 7:173-83.
6. Westermeyer J, Bouafuely M, Neider J, Callies A. Somatization among refugees: An epidemiologic study. Psychosomatics 1989; 30:34-43.
7. Westermeyer J, Neider J, Callies A. Psychosocial adjustment of Hmong refugees during their first decade in the United States. J Nerv Ment Dis 1989; 177:132-9.
8. Lin E H B, Carter W B, Kleinman A M. An exploration of somatization among Asian refugees and immigrants in primary care. Am J Public Health 1985; 75:1080-4.
9. Nguyen S D. Psychiatric and psychosomatic problems among Southeast Asian refugees. Psychiatr J Univ Ottawa 1982; 7:163-72.
10. Nicassio P M, LaBarbera J D, Coburn I', Finley R. The psychosocial adjustment of the Amerasian refugees. Findings from the Personality Inventory for Children. J Nerv Ment Dis 1986; 174:541-4.
11. Tseng W S. The development of psychiatric concepts in traditional Chinese medicine. Arch Gen Psychiatry 1973; 29:569-75.
12. Tseng W S. The nature of somatic complaints among psychiatric patients. Compr Psychiatry 1975; 16:237.
13. Kleinman A. Depression, somatization and the "new cross-cultural psychiatry." Soc Sci Med 1977; 11:3.
14. Yap PM. Mental diseases peculiar to certain cultures: a survey of comparative psychiatry. J Mental Sci 1951; 97:313-27.
15. Leff J I'. Culture and the differentiation of emotional states. Br J Psychiatry 1973; 123:299-306.
16. Hsu F L K. Suppression versus repression. Psychiatry 1949; 12:223.
17. Lin T Y, Ling M C. Love, denial and rejection: responses of Chinese families to mental illness. In: Kleinman A, Lin T Y, editors. Normal and Abnormal Behavior in Chinese Culture. Holland: D Reidel Publishing Co, 1981:387-401.

18. Singer K. Depressive disorders from a transcultural perspective. Soc Sci Med 1975; 9:289-301.
19. Cheung F M. Psychological symptoms among Chinese in urban Hong Kong. Soc Sci Med 1982; 16:1339-44.
20. Kirmayer L J. Cultural affect and somatization. Transcultural Psychiatr Res Rev 1984; 21:159-88.
21. Fabrega H. Cultural relativism and psychiatric illness. J Nerv Ment Dis 1989; 177:415-25.
22. White G M. The role of cultural explanations in "somatization" and "psychologization". Soc Sci Med 1982; 16:1519-30.
23. Kleinman A, Kleinman J. Somatization: interconnections in Chinese society among culture, depressive experiences and the meanings of pain. In: Kleinman A, Good B, editors. Culture and Depression. Berkeley, CA: University of California Press, 1985.
24. Hauff E, Vaglum I'. Chronic posttraumatic stress disorder in Vietnamese refugees. A prospective community study of prevalence, course, psychopathology, and stressors. J Nerv Ment Dis 1994; 182:85-90.
25. Barrett W. Death of the Soul. From Descartes to the Computer. New York: Anchor Press / Doubleday, 1987.
26. Mollica R F, Wyshak G, Lavelle J. The psychosocial impact of war trauma and torture on Southeast Asian refugees. Am J Psychiatry 1987; 144:1567-72.
27. Morris I', Silove D. Cultural influences in psychotherapy with refugee survivors of torture and trauma. Hosp Community Psychiatry 1992; 43:820-4.
28. Beiser M, Fleming J A E. Measuring psychiatric disorder among Southeast Asian refugees. Psychological Med 1986; 16:627-39.
29. Yamamoto J, Yeh E K, Loya F, Slawson I', Hurwicz M. Are American psychiatric outpatients more depressed than Chinese outpatients? Am J Psychiatry 1985; 142:1347-51.
30. Cheung F M, Lau B W K, Waldmann E. Somatization among Chinese depressives in general practice. Int J Psychiatry 1981; 10:361-74.
31. Cheng TA. Symptomology of minor psychiatric morbidity: a crosscultural comparison. Psychological Med 1989; 19:697-708.
32. Bourne P G. Suicide in the Chinese of San Francisco. Trans Psychiatr Res Rev 1970; 7:210-2.
33. Lalinec-Michaud M. Three cases of suicide in Chinese-Canadian women. Can J Psychiatry 1988; 33:153-6.
34. Katon W, Ries R K, Kleinman A. The prevalence of somatization in primary care. Compr Psychiatry 1984; 25:208-15.
35. Silove D, Tam R, Bowles R, Reid J. Psychological needs of torture survivors. Aust NZ J Psychiatry 1991; 25:481-90.
36. Boehnlein J K, Kinzie J D, Ben R, Fleck J. One-year follow-up study of posttraumatic stress disorder among survivors of Cambodian concentration camps. Am J Psychiatry 1985; 142:956-9.
37. Hong G K. A general family practitioner approach for Asian-American mental health services. Prof Psychol Res Practice 1988; 19:600-05.
38. Chin J L. Diagnostic considerations in working with Asian-Americans. Am J Orthopsychiatry 1983; 53:100-9.
39. Grauer H. Geriatric depression in the West and the Far East. Psychiatr J Univ Ottawa 1984; 9:118-20.