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THE ANGRY LIVER, THE ANXIOUS HEART AND THE MELANCHOLY SPLEEN

The Phenomenology of Perceptions in Chinese Culture

ABSTRACT. The purpose of this article is to advance a different approach to the phenomenology of the "lived-body." To understand the role of the body in generating culture, traditional constraints influencing bodily perceptions are considered. The alternative is found in the phenomenological method of bodily perceptions. Numerous examples from traditional Chinese medicine, based on research in China, illustrate a wealth of symptoms, sensations, and their relation to the world of emotions. These examples provide arguments for collapsing the strict distinction between somatic changes and emotions as based in the dichotomized view of mind and body, subject and object. The analysis also includes the semantic dimensions of these bodily processes.

INTRODUCTION

During the last decade, medical and psychiatric anthropologists have increasingly turned their attention towards the body. Evident in this recent work is a new approach. Whereas most of the older anthropological writings dealt with the body in its symbolic, metaphorical and representational significance for society and culture, i.e., with the body as inscribed by culture, newer writings deal with the body's role and importance in creating this culture (Shipperges 1975, 1981, Kirmayer 1984, Shapiro 1985, Levin 1985, Frank 1986, Johnson 1987, Scheper-Hughes and Lock 1987, Csordas 1990).

The purpose of this article, then, is to argue that in the future, anthropological research must pay more attention to the role the body plays in the creative and constitutive processes that shape culture. Which body do I mean? In this paper I am not concerned with the ways society and culture construct, shape and inscribe the body. Nor do I mean the body as reflected in our presently constrained cultural view of biology, i.e., the physical body of corporeality, of structure, matter, morphology, and physiology in contrast with emotions and the mind, the body "purged of spontaneity, willfulness and occult desires" (Leder 1984: 30). I mean the phenomenological body of perceived experiences, the lived-body that transcends the dichotomy of psyche and soma.

For Merleau-Ponty (1962: 79) it is this body that constitutes our "being in the world," and the body is a "setting in relation to the world." As Schipperges (1981) showed for Paracelsus, Novalis and Nietzsche, Merleau-Ponty views consciousness as the projection of the body into the lived world; or, in other words, the world becomes an extension of the body. He gives utmost importance

to the phenomenology of perceptions, which he sees as the starting point of our consciousness of the world. For him perceptions are "pre-objective," yet not pre-cultural; they start in the body and "end in objects." Thus perceptions are the preconditions for cognition and reflective thought and not their secondary products.

What, then, is the present and future task of a phenomenologically oriented medical anthropology? "Phenomenology is a descriptive science of existential beginnings, not of already constituted products. If our perception 'ends in objects', the goal of a phenomenological anthropology of perception is to capture that moment of transcendence in which perception begins ..." (Csordas 1990).

What are perceptions? This question leads to an old and central epistemological problem in anthropology, the twofold character of our analytical tools. We believe that we can understand and describe the culture-specific ways by which other people experience and see themselves and their worlds. We describe them within our modes of thought. In so doing we recognize the specific cultural ways which shape our thinking. We then ask ourselves whether our concepts allow us to understand how others think. Maybe our concepts inhibit an understanding of the other. This problem becomes even more acute when the concepts of others are not just a different mode of thought but can be viewed as created by a different kind of bodily perception, e.g., the concept of *qi* in Chinese culture (Ots 1987: 45). Modern Western man's thought and language has been strongly influenced by the dichotomy of psyche and soma implying the superiority of the intentional mind over the intentionless body. Dualistic thought restrains and circumscribes bodily perceptions and bodily awareness, it alienates "us" from our body: it is the mind thinking of the body rather than the body perceiving itself. Thus the difficulty of cross-cultural translation of concepts between dualistic and monistic modes of thought is but another facet of the difficulty of translating between the mind and the body. If we want to know more of the "body sui generis," we must relearn to perceive without these restraints, i.e., perceive in a "pre-objective" way.

It is a difficult task. How should we approach it? I begin by giving examples of the richer view of the perceiving body in Chinese culture. I hope my presentation will not only elicit our culturally constrained view, but encourage new approaches towards the body. I will demonstrate bodily perceptions as communicated in the context of traditional Chinese medicine. They differ from our bodily perceptions not only in a phenomenological sense, but also by being embedded into a different semantic network. Thus my analysis takes a phenomenological as well as semantic approach. Although most of the given examples are descriptions of the way Chinese patients communicate their problems, my analysis, in part, relies on my own changed perceptions. Over a period of three years in China, I have worked as a physician-researcher within traditional

medicine. Being together with the patients and witnessing their suffering influenced my bodily awareness. As I will show later there are some symptoms that cannot be primarily understood on a cognitive level but have to be felt. Of course, I cannot claim that I succeeded in perceiving like my Chinese patients (whoever can make this claim!), but after long periods of not understanding what the patients were talking about, I became sensually aware of some of their symptoms, i.e., at the level of bodily perception.

The main difference in perception and labelling between traditional Chinese medicine and Western biomedicine is the understanding of the relation/identity of psyche and soma. This difference is paradigmatic and requires a short discussion of the Western concept of somatization/psychologization in relation to the paradigm of the lived-body. This discussion also creates a basis for understanding the Chinese data which follow. These include presentation of cases and a detailed semantic/phenomenological analysis of some of the most common symptoms. I will conclude with a look at the implications of this finding for future phenomenologically oriented anthropological research and for the epistemological problems of Western psychosomatic medicine.

SOMATIZATION

The accumulated experience of traditional Chinese medicine supports old and new hypotheses in the West that view psychologically affected disorders as psychobiological entities. Different cultural values determine whether this entity is interpreted in a more holistic or in a more dualistic way. The cultural legitimation of emotional disorders produces an emphasis on the psychological aspects of bodily disorder, while the cultural stigmatization of emotional disorders leads to an emphasis on the somatic aspects of illness. Both views can be understood as culturally constructed modes of interpretation that shape perception, interpretation, labeling and help-seeking. In the industrialized Western countries, psychologization has become the predominant view of interpretation for disorders which show psychological and emotional distress while somatic manifestations in these disorders are interpreted as "secondary" or "non-specific" and are more or less neglected. Conversely, traditional Chinese medicine gives utmost importance to somatic dysfunctions. Each approach has given rise to a reliable culture-specific medical disease classificatory system.

During the last two decades, somatization has received increasing attention in cross-cultural anthropological research, particularly in cross-cultural psychiatric research. Lately, our conceptual understanding of somatization has become more self-critical of the earlier Western anthropological and still dominant Western medical interpretation of somatic complaints in emotionally affected disorders as an illness construct, separate from the "real" disease. Von Uexküll

(1963) who is one of the early European critics of the concept of somatization, defined emotional disorders as "integrated organismic reactions" to environmental stimuli, and interpreted emotional and somatic distress as two aspects of one "psychobiological entity." Kleinman (1986: 60) pointed out that today somatization must be interpreted as a "particular cognitive-behavioral type whose adaptive or maladaptive consequences involve assessment of social, cultural, and personal variables." He argues that "counter to the established views of Western mental health professionals, from the cross-cultural perspective it is not somatization but psychologization in the Western middle and upper classes that is unusual and requires explanation" (Kleinman 1986: 56). Worldwide, the primary presentation of bodily complaints is the most common type of presentation of psychobiological affect. It is more common in third world countries, and it is more prevalent in Europe than North America. In Europe it is more common in less industrialized countries. Within specific countries it correlates with rural origins, lower socioeconomic and educational levels, and traditional value orientation.

From a historical perspective, psychologizing behavior in the West is rather young. The mode in which diseased persons perceive and present symptoms is determined by the way psychosocial problems are understood, and the way the health care system is structured. Until only a few decades ago, psychosocial problems were not yet perceived and labeled as medical problems and were consequently not dealt with by the physician but by the family, friends, and the priest! Only the concomitant bodily problems were brought to the attention of the physician.

In a review essay, Kirmayer (1984) recently presented seven contemporary models of somatization. Only one of them refers to somatization as a bodily manifestation (correspondence, equivalent) of emotion. The other six concepts focus on somatization predominantly as a culturally patterned construct, as the modelling of a primarily psychological event into a secondary somatic expression, i.e., as an abnormal illness behavior. Most often, somatization is interpreted as an emotional deficiency. This is most pronounced in the concept of alexithymia that interprets somatization as a person's inability to describe feelings (Nemiah and Sifneos 1970), and by an absence of fantasies (Marty and M'Uzan 1963). Yet, in the past, many Western schools of medicine, especially schools of psychosomatic medicine, developed hypotheses that, to varying degrees, coincide with the findings of traditional Chinese thought which sees emotional and bodily expressions of distress as corresponding and thus specific. In an exhaustive overview article, Weiner (1986) provided ample evidence that during the two millennia since Hippocrates and Galen, many physicians and medical schools have concluded that there exists a specific relationship between emotions and bodily changes. I want to give a few examples from this century.

Cannon (1911) demonstrated that fear, fright, and anxiety in dogs led to an inhibition of the secretion of gastric fluid as well as gastric motility. He coined the term "wisdom of the body" (1939). Braun (1920) interpreted the heart as the specific receptor of fear. Fear might cause tachycardia, arrhythmia, and angina pectoris. Wolff and Wolf (1943), who had the unique chance to conduct research on a patient with a gastric fistula, showed that fear and fright led to an inhibition of gastric secretion whereas anger led to an increase of secretion and of gastric motility. Cannon (1911; 1953), Wolff (1950; 1953), and Alexander (1951) interpreted human vegetative homeostasis in the two-directional manner of activation (fight and flight) and passivity (withdrawal-conservation). Alexander found increased arousal of the sympathetic nervous system in acts of fight and flight, and increased arousal of the parasympathetic nervous system in the state of withdrawal-conservation. Alexander advanced the hypothesis of symptom-specific psychodynamic conflicts; by analyzing a specific psychodynamic conflict, he and his group (Alexander, French and Pollock 1968) were able to predict bodily symptoms to a statistically relevant degree. Many of the symptom-conflict disease patterns that Alexander described correspond with those of traditional Chinese medicine.

SOMATIZATION IN CHINA

Presenting somatic complaints is the main mode of medical care-seeking behavior in Chinese culture. This behavior is not essentially different in the Peoples Republic of China, Taiwan, Singapore, or Hong Kong. There exists a long-standing tradition of repression of emotions that is mainly based on Neo-Confucian ideals concerning correct social behavior. Emotional excess is severely stigmatized. High value is placed upon the moderation and inhibition of emotions and their public expression (Kleinman 1980; Lin 1985).

Precisely how Chinese perceive emotional distress has been a matter of controversy. Kleinman (1980: 148) argued that Chinese keep distress undifferentiated; other related coping strategies are minimization, dissociation, and somatization. Cheung (1986: 199) argued that the psychological suffering of Chinese and their awareness of it cannot be assessed by analysis of the clinical setting alone. Research has demonstrated differences between public and private presentation and expression of emotional affects among the Chinese (Bond and Huang 1986; Cheung 1986). Cultural norms prevent Chinese from talking freely to a stranger, i.e. to those "outside" their "life-managing group." Usually, the doctor is such a stranger, especially the doctor in a clinic who does not visit the patient at home. Many reports indicate that more emotional permissiveness exists within the "inside" context (Cheung, Lau, and Waldmann 1981; Cheung 1982; see also Ohnuki-Tierney 1984 for Japan).

It seems that this controversy reveals as much about the conceptual limita-

tions of the Western observers as about the Chinese. We cannot but think within the limits set by the dichotomy of body and mind. In fact, this dichotomy exists also in Chinese thought. The dominant philosophical traditions Confucianism, Neo-Confucianism, and Daoism view the heart (*xin*) as the governing organ and the seat of the mind, and that is supposed to control the organs and the emotions. This view seems to equal the Western view. Yet, somatic functions and emotions are not strictly separated. Emotions are merely understood as pathogenic factors which cause disturbances of the organs and their functions. There exists a long tradition of expressing emotions in somatic metaphors. This tradition, in part, is based on the sophisticated and systematized observation of the correspondence of emotional and somatic complaints. Thus specific emotional changes and specific somatic dysfunctions are viewed as corresponding with each other and often as identical. The difference between the Western and the Chinese view is not that of a dichotomized Western and a supposedly holistic Chinese view of body-mind. The difference lies in the Chinese assessment of an emotional body.

On a phenomenological level this means that somatic changes are not differentiated from the concomitant emotional changes and repressed as is the case in cultures with a psychologizing view. Somatization and psychologization appear as two sides of the same psychobiological entity. The difference is a difference in focus. In respect to the phenomenology of bodily perceptions it is the Chinese who have a less restricted bodily perception and thus might serve us as an example of a different bodily awareness. Chinese are culturally trained to "listen" within their body.

THE *LEIB*

It should have become clear by now that I reject the term somatization as it is commonly used. This term is deeply embedded in the Western concept of mind-body dichotomy and its value system that privileges the superior mind over the inferior body. The identical dichotomy lurks behind the etymology of the term "embodiment": something else takes possession or enters the body. Etymologically, body stems from the old Saxon *bodig* (in current German *Bottich*) which means "vessel." The body is understood as a vessel for the mind. The terms somatization and embodiment both rely on a processual change and are thus directional and temporal; they understand the body as an object of the mind.

We are reminded of Wittgenstein's (1979: 49e) aphorism that the "limits of my language mean the limits of my world." The English-speaking world lacks a word to express body-mind unity. Another term is that of the "lived-body" (Leder 1984) which I prefer over "embodiment," but which bears the disadvantage that it is composed out of dichotomic aspects. In German, there still exists a (pre-dichotomic) term that denotes the body-mind entity: *Leib*.[1] It is used, for example, by the philosophers Nietzsche, Husserl, Heidegger, the medical historian Schipperges, and also by the priest, who in communion offers the *Leib* of Jesus. It is the *Leib* that rejoices and enjoys or suffers. If somebody cares for somebody else's *leibliches Wohl*, then this means his bodily as well as and psychic wellbeing. It would be interesting to see to what extent this linguistic difference has influenced the development of phenomenology (many of the theorists of this school are Germans), but even more important, in what way it makes people feel, experience and perceive differently, i.e., in a less restrained way. It would be equally interesting to see in what way this concept has influenced and whether it might, in some measure, account for the differences in medical care in Germany and North America. Psychosomatic thought, naturopathy and *leib*-oriented healing approaches are integrated into German biomedicine and the German health care system to a degree unimaginable in North America.

THE NANJING STUDY ON PSYCHOSOMATIC DISORDERS IN A TRADITIONAL MEDICAL SETTING

Research Problem

This study is based on research done between September 1984 and March 1985 at the Jiangsu Provincial Hospital of Traditional Chinese Medicine, the teaching arm of the Nanjing Institute of Traditional Chinese Medicine (hereafter, TCM). All of the 243 subjects for this study were patients of the outpatient clinic for internal medicine. The scope of patients who consulted this outpatient clinic could be compared with those who would consult a general practitioner in the West.

The study was conducted to provide insight into the correspondence of emotions and bodily complaints in psychosomatic disorders.[2] In particular, I investigated whether there were specific bodily symptoms or symptom patterns that enabled traditional doctors to identify certain emotional changes. The study thus explored the meanings of bodily perceptions in the discourse of traditional Chinese medicine as well as in patients' explanatory models.

Research Method

The research was carried out in one of five rooms of the outpatient department. Our room was not different from any other room. The research was organized as

to interfere minimally with the doctor-patient interaction. The patients did not identify me as a researcher, but as a foreign doctor who had come to study TCM. My research did not follow any specific research protocol, and no questionaires were used. All data were recorded by hand in the actual order.

The research was conducted primarily with one traditional Chinese doctor, a woman, for whom other doctors occasionally substituted at the clinic, and with her patients. The patients usually addressed the Chinese doctor first, she conducted the primary interview and traditional diagnostic methods like the pulse- and tongue diagnosis. After she was finished, I carried out the pulse and tongue diagnosis with each of the patients and did most of the physical examinations. After my Chinese colleague had reached her diagnosis, and before she disclosed her diagnosis to me, I inquired about the emotional life of the patients, using an open-ended interview technique. The interviews were ended by the next patient pressing in.

Patient-Doctor Interaction

Many patients initially were reluctant to air more than one main complaint. This behavior can be interpreted in the light of an old belief that a good doctor should not ask many questions (Kleinman 1980; Wu 1982). Over the centuries, the idealized picture of a good doctor was the old, grey-haired *lao yi* (literally: old doctor) who did not pose any questions at all, but just felt the pulse and then wrote out a prescription. But once the doctor had begun her interrogation of the patients, they became very eloquent and enjoyed describing their complaints.

While my Chinese colleague was feeling the pulse and inspecting the tongue, she posed further questions which aimed at somatic dysfunctions. Generally she exhibited little interest in studying the patients' medical records, many of which were quite extensive, indicating that they had already been suffering from a long "patient career." The Chinese physicians I encountered almost never inquired about the patient's biography. They would not do so even when the patients did not conduct themselves in the culturally sanctioned quiet and disciplined manner but instead demonstrated their suffering in an open fashion by moaning, sighing, hanging the head or laying it on the table, or even crying. This lack of verbal communication in the discourse of TCM might be interpreted as the outcome of specific diagnostic techniques developed by TCM, such as the correspondence between bodily symptoms and emotions. If the doctor is able to detect the patient's emotional changes by observation of bodily dysfunctions, and, further, if it is beyond the doctor's ability to influence a change of the patient's psychosocial environment, then why should he inquire into the personal and social domain? Traditional Chinese medicine is fundamentally disease oriented (Eisenberg and Kleinman 1981). Most often the patients did not hesitate to talk

about their emotional situation with me. They told me that they were angry or anxious, and they usually referred to a specific encounter, but our discussions did not go far beyond these statements. They probably did not view this discussion with me as part of the medical interaction but thought of it as a chat. Generally, consultations in TCM last only a few minutes, of which the drawing up of the prescription requires a relatively large amount of time. By my presence and interaction, the consultations became two or three times as long as usual. In most cases my Chinese colleague prescribed a concoction of 10 to 15 different drugs. Patent medicines were the exception.

Emotions in the Understanding of Traditional Chinese Medicine

The concept of *qi qing zhi bing* (seven emotions that induce disease) was useful when I discussed my research plans with the directors of the clinic.[3] My plans were received favorably though I had expected difficulties or even rejection. In view of my Beijing experiences four years earlier, this was surprising. In Beijing I had not achieved a mutual understanding with my Chinese teachers that permitted us to discuss psychological problems. Whenever I claimed that a certain patient was suffering from an emotional disorder and argued that diagnosis should include his biography and should elicit his psychosocial background, my teachers referred to their way of diagnosing and labeling as an appropriate method. I had used the modern Chinese term *xinli de wenti* (mental problem; literally: problem of the heart). In TCM the heart is viewed as the overall governing organ and the seat of the mind which rules the somatic and affective aspects of the body; I had interpreted the patients' disorders within a framework of stigmatized mental disease whereas the Chinese doctors applied culturally legitimized somatic idioms. The concept of "seven emotions" bridges the gap between these two concepts. The disorder is viewed as induced or aggravated by emotional factors producing somatic dysfunctions. Dysharmonic emotions are understood as pathogenic etiological factors, not as part of the disorder. This interpretation of emotions as etiological factors implies that the treatment is not primarily oriented towards emotional change. The treatment tries to harmonize the emotions by harmonizing bodily functions. Our psychological approach which in China is interpreted as mental education (Ots 1987: 160) does not fall into the realm of the medical system. Serious mental disease was rarely dealt with by TCM, but by other healing approaches like shamanism and religious healing (Kleinman 1980); today, it falls into the realm of Western medicine.

A professional intimacy quickly developed between my Chinese colleague and myself. After about two weeks we required little time deliberating on whether a particular patient's disorder could be classified as affected by the

"seven emotions." There was very little dissent.

Data of the Study

270 patients consulted us during the three-month period of investigation. For various reasons, the data from 27 of these patients was incomplete, so that this study includes only 243 patients. 106 of these patients (44 percent) were classified as suffering from a psychosomatic disorder. Due to limitations of space only those data are given here that show the relation between bodily symptoms and the organs as given in the traditional physician's diagnoses.

Table I provides correspondences between physical symptoms and individual organs that show three characteristics:

(A) Symptoms characteristic of a single organ only.

(B) Symptoms characteristic of two or more organs.

(C) Symptoms clearly corresponding with a particular organ, but which can also become the symptom of another organ in a specific organ combination. The latter situation symbolizes disease dynamics, e.g., heart or liver disorders affecting the spleen.

These three types of correspondences are demonstrated in Table II.

CASE STUDIES

The following case studies illustrate the normal procedure of patient-doctor interactions in TCM. They give the reader an idea about the multitude of bodily perceptions that are taken seriously by the traditional doctor, whereas in the context of biomedicine identical symptoms are often ignored by the physician. The case studies demonstrate how the traditional doctors diagnose emotional distress out of a set of seemingly somatic symptoms.

The order of complaints in the case studies follows that in which patients volunteered their complaints or in which these complaints were elicited through the doctor's questions. The heading I provide for each case describes the emotional situation or main symptoms of the patient. It does not indicate a Western medical diagnosis. The Chinese diagnosis is given in the text. The vignettes are incomplete; I have eliminated some information used by the doctor in reaching a diagnosis but not relevant for my purposes here, for example, the inquiries of the pulse and the tongue.

TABLE I
Correspondences of symptoms with organs named in the diagnoses of 106 patients

	Number of cases	In % of cases	Liver	Heart	Spleen	Kidney
1. vertigo	38	36%	20	10	8	12
2. anger	36	34%	32	2	17	3
3. insomnia	29	27%	11	16	2	3
4. belching	27	25%	25		16	
5. abdominal discomfort	24	22%	18		16	
6. constipation	22	21%	21	2		
7. palpitations	20	19%	8	14		
8. thoracic depression	20	19%	17	1	9	
9. loss of appetite	19	18%	11		13	
10. blurred vision	19	18%	11	7		5
11. frigophobia	18	17%	5	2	10	
12. vomiting	17	16%	14		10	
13. nausea	17	16%	15		6	
14. lumbago	15	14%	5	3		6
15. abdominal distention	14	13%	12		9	
16. increased dreaming	14	13%	5	8	1	
17. headaches (incl. 3 cases of migraine	14	13%	9	6		
18. epigastr./right subcost. pain	13	12%	13			
19. frailness	10	9%	2	1	7	1
20. distressed heart	10	9%		7		
21. tinnitus	9	8%	2		2	5
22. diarrhea	9	8%	2		7	
23. globus hystericus	8	8%	7			
24. sweating	8	8%	1	5	2	
25. retrosternal globe	8	8%	3		5	
26. flank pain	8	8%	8			
27. dry mouth	7	7%	2		4	
28. sexual dysfunctions	7	7%		2		5
29. sighing	7	7%	6		1	
30. hypertension	6	6%	4	2		
31. numbness of four extrem.	4	4%	1		3	
32. neck pain	2	2%		2		

Explanation: Differences in the amount between "number of cases" and the sum of symptoms of the individual organs are due to the fact that most of the diagnoses named two afflicted organs. Thus, the sum of symptoms of individual organs may exceed the number of cases. Anger was included in this list of bodily symptoms because it was the only emotional symptom voluntarily brought forth by the patients.

TABLE II
Correspondences between symptoms and organs

Group A: Symptoms characteristic of a single organ

liver	heart	spleen	kidney
anger (32)	insomnia (16)	loss of appetite (13)	lumbago (6)
belching (25)	palpitations (14)	frigophobia (10)	sexual dysfunction (5)
constipation (21)	increased dreaming (8)	diarrhea (7)	tinnitus (5)
thoracic depression (18)	distressed heart (7)	frailness (7)	
nausea (16)	sweating (5)	dry mouth (4)	
epigastric/right subcost. pain (13)	neck pain (2)	numbness of 4 extrem. (3)	
headaches incl. migraine (9)			
flank pain (8)			
globus hystericus (7)			
sighing (6)			
hypertension (4)			

Group B: Symptoms characteristic for two or more organs

liver	heart	spleen	kidney
vertigo (20)	vertigo (10)		vertigo (12)
abdominal discomfort (16)		abdominal discomfort (18)	
vomiting (14)		vomiting (10)	
abdominal distention (12)		abdominal distention (9)	
blurred vision (11)	blurred vision (7)		blurred vision (5)
retrosternal globe (3)		retrosternal globe (5)	

Group C: Symptoms clearly corresponding with one particular organ, and in the course of pathodynamics also afflicting another organ

liver:	liver-heart	liver-spleen
	headaches (6) hypertension (2)	anger (17) belching (16) thoracic depression (9) nausea (6)
heart:	heart-liver	
	insomnia (11) palpitation (8) increased dreaming (5)	
spleen:	spleen-liver	
	loss of appetite (11) retro-sternal globe (3)	
kidney:	kidney-liver	
	lumbago (5)	

Case 1. Nausea, Angry Vomiting

A 38-year-old cadre has been sent to Nanjing for political studies three weeks ago. The studies will last another ten days. He is very pale, talks slowly, and seems to be in low spirits. His complaints: Whenever he is asked to talk or to answer questions at his meetings, he experiences nausea and palpitations. A few times he has had to vomit, but most often brings nothing up. He has lost his appetite. Sleep is not disturbed. He also has the urge to burp, but nothing happens. It all got started right before he was sent to Nanjing. Whenever he sits down to study books and documents, his complaints increase. He denies that his studies trouble him. "*Xuexi bu jinzhang*" ("The studies don't put a great strain on me."), he says. He points to his liver and says: "*Zherli fa men*" ("Here I experience the feeling of *men*"; see "meaning of symptoms" No. 8). Lately he suffers from dry stools. He also experiences vertigo and blurred vision. He has lost interest in everything, e.g., he does not even watch TV.

He has been seeing the outpatient department in a Western clinic, but the doctors were unable to give him a diagnosis.

Traditional diagnosis: deficiency of blood (*xue xu*); blocked liver, liver lost ability of catharsis (*gan yu*; *gan shi shu xie*); the *qi* of the stomach lost its proper direction (*wei qi shi jiang*).

Therapeutic principle: nourish blood (*yang xue*); harmonize liver (*tiao gan*); regulate the flow of *qi* of the stomach (*li qi he wei*).

Therapy: Prescription of twelve different herbs.

We see him again three days later. He feels much better. There is no more vomiting, and he suffers from nausea only in the morning. The stools are not dry any more. He started to pass winds, but he cannot burp yet. He mentions that the course will be over within a week.

Interpretation: The patient obviously was suffering from being sent away from home. He felt less afraid of his studies than oppressed by the whole situation. He did not like the documents he had to read, and because he could not escape the situation, he began to vomit. Interestingly, he was the only patient who literally felt his oppression at the site of the liver. Whenever he was addressed during the studies he also felt nervous and anxious. The traditional diagnosis referred to liver-blocked anger as well as to stomach/spleen, and also to his pale looks. The medicines helped him to feel better as they gave him some somatic relief. The main relief must be seen in the fact that the stressful situation was about to end soon. It is interesting to note that the Western doctors were unable to diagnose his illness, which showed mainly symptoms of the blocked liver. If the situation had lasted over a longer period of time, it might have turned into a depression.

Case 2. Anger; Gallstones

A 51-year-old lady, who is an unskilled worker, rather fat, with the typical aggressive facial expression associated with the liver, with an overtone of aggressive smiling, complains that after work she feels abdominal pain. She mentions a long history of epigastric pains. In 1977, she suffered from gastric ulcers. A Western clinic performed a partial gastrectomy on her, but the pains never ceased. In 1981 an appendectomy was performed. No change in her pains. The pains increase when she feels tired, also with changes in the weather. She gets tired easily. She can't eat fatty foods or milk, because she will suffer from loose stools afterwards. But usually she suffers from dry and hard stools, and even takes laxatives. She often vomits yellow and bitter fluids. She also suffers from vertigo, and sometimes from blurred vision.

Examination: I palpate her abdomen while her eyes are closed. Whereas she had initially pointed to the epigastric region, she now feels pain over the gall pole. She also admits that, occasionally, the pain radiates to the right scapula. I ask her whether she easily gets angry. "Oh yes, very often. Whenever I get angry, I feel even more pain." "Do you sometimes fly into a rage?" "Yes, often. I like to fight."

Traditional diagnosis: deficiency of blood and *yin (yin xue bu zu)*; weak *qi* of the spleen (*pi qi bo ruo*); liver and gall bladder lost ability of catharsis (*gan dan shu xie*).

Therapeutic principle: nourish the blood and increase *qi (yang xue yi qi)*; strengthen the spleen and harmonize the liver (*jian pi tiao gan*).

Therapy: Prescription of nine different herbs.

My Chinese colleague argues that the patient probably has been suffering from gallstones for many years. She arranges an ultrasonography which shows massive cholelithiasis.

Interpretation: According to TCM the patient obviously suffered from a disorder of the gall bladder. This had gone undetected by the Western doctors who centered their reasoning on the stomach. When we saw this patient, I had been working in the out-patient department for a month, and I made up my preliminary diagnosis according to the patient's typical facial expression, which corresponded positively with the symptoms. The diagnosis added an additional deficiency of the spleen (easily tired, vomiting) and a general weakness (*yin* and blood) that was also evidenced by the pale and fat tongue.

Case 3. Anxiety and Depression

A 30-year-old unmarried female worker; very pale, whining voice, seems depressed, wears big glasses that almost hide her face. When it is her turn to address my colleague, she does not speak, but hands over her medical record. After my colleague has taken a look at it, the patient remarks that she has been hospitalized four times during the last few years. She does not say why. Then she gives the following complaints: She suffers "terribly" from gastroptosis (flaccid elongation of the stomach). Lately, she has also experienced vertigo and "heart distress" for over a week. She sweats profusely, and her hands are wet, cold, and trembling. Her stomach trouble is resolved at present because she is very careful about her food. She takes in only small amounts at a time, and eats no vegetables, only fish, eggs, and meat. She does not eat cold food, although she would like to. She suffers also from low back pain.

Ten years ago Western medicine diagnosed Wolf Parkinson White syndrome (a somatic heart lesion with a rather good prognosis). They wanted to operate on her, but she refused. She has caught a cold; she coughs slightly. She has trouble sleeping, and she dreams a lot. She feels afraid of cold (*pa leng*). Half a year ago she joined a class of Crane-*qigong*, a newly developed form of meditational movement exercise that favors cathartic experiences (*zi fa gong*; see Ots 1987; 1987a). As she never experienced catharsis she stopped the exercises. All her troubles began five years ago.

Traditional diagnosis: deficiency of *qi* and blood (*qi xue bu zu*); the heart lost its proper nourishment (*xin shi suo yang*).

Therapeutic principle: increase the *qi* and nourish the blood (*yi qi yang xue*); calm the mind (*an shen*).

Therapy: Prescription of eleven different herbs.

We see her again four days later. Now she seems even more depressed. She suffers from abdominal pains and an extremely bitter mouth (*kou ku*). She also feels nauseated, but she cannot vomit.

Therapeutic principle: strengthen the spleen (*jian pi*); warm the center, disperse the cold (*wen zhong san han*); regulate the *qi* of the stomach (*li qi he wei*).

Interpretation: Although this woman had been labelled as suffering from a heart disease ten years ago, her actual suffering began five years ago. At that time she was 25 years of age and was expected to marry. For reasons unknown to us she did not find a husband, which created a fair amount of anxiety in her life. She started to suffer from "anxious heart." Over the years this illness worsened, and the pathodynamics of the heart pointed towards the melancholy spleen. When we saw her for the first time, she displayed mainly symptoms of

the heart (distressed heart, sleep disturbance, increased dreaming, sweating, and trembling hands) as well as of the spleen (gastroptosis, and frigophobia). The traditional doctor viewed the symptoms of the heart as most important. When we saw the patient the second time, she displayed only three symptoms, all of which corresponded with the spleen. The focus of therapy shifted to the spleen-melancholy.

Case 4. Anxiety Turning into Anger (Neurasthenia in China's Western Medical Terms)

A 25-year-old female worker. She is quiet, her voice low and whining. Her face has a greyish-yellow complexion and seems slightly swollen, especially around the eyes as if she had recently been crying.

Her complaints: She suffers from headache. She cannot fall asleep. She sweats profusely. There is also some pain on the right side of the thorax, lasting one week. She feels very weak. At this point the female doctor asks her whether she is unhappy, and whether she experienced any difficulties and problems lately. The patient denies this. Her symptoms began about three months ago. Now she adds that she got married two weeks ago. At times she experiences palpitation and "distressed heart." Lately she has also felt thoracic depression (*xiong men*). I inquire again about her emotional state of health. She admits that she loses her temper easily (*rongyi fa pi qi*).

Traditional diagnosis: deficiency of heart-*yin* (*xin yin bu zu*); the liver lost its harmony (*gan shi tiao chang*); the mind lost its calmness (*shen shi an she*).

Therapeutic principle: Nourish heart-*yin*; harmonize liver-*qi*; calm down heart-mind (*an xin shen*).

Therapy: The doctor writes out a prescription of eleven herbs.

Interpretation: Although the patient denied being unhappy she was obviously in a state of anxiety and irritability. She had married two weeks prior. Obviously, this was not a happy marriage. She must have anticipated her unhappy liaison, because her symptoms began about at the time when she started to prepare for the marriage three months earlier. The traditional diagnosis points out her heart-anxiety that later had progressed into liver-anger. The traditional doctor remarked that this patient was suffering from neurasthenia.

Case 5. Anger Misinterpreted as Heart Disease

I want to add a case out of my practice in Germany in order to demonstrate some cross-cultural identities of emotion-symptom correspondences and their neglect by biomedicine. At night I was called by a 57-year-old female patient who said that she suffered from a serious heart disease and that she was afraid of a heart infarct. When I saw her in her home she sat at the kitchen table with her head in her hands. Her face had a greyish complexion. It was certainly not pale, particularly not around the oral region as is often the case in heart failure. There were also no signs of cold sweat. Her pulse was rhythmic and strong. When I auscultated her heart I heard strong bowel sounds, instead. Obviously the diaphragm was elevated by serious abdominal distention. She conceded suffering also from migraine, globus hystericus, and occasional attacks of thoracic depression. Her past history revealed duodenal ulcers.

When I told her that she was not suffering from a heart attack, she seemed unrelieved. I asked her whether something had made her unhappy or whether she had become angry lately, and at this point she started to cry. I learned that she was a librarian. She had planned a summer vacation, but the day before, one of her colleagues fell ill and she was asked to replace her. She dared not oppose this request. Afterwards she felt a lump behind her sternum (retrosternal globe), and a few hours later the assumed heart pain began. While she talked she burped constantly, but she denied experiencing this when I questioned her about it. She responded affirmatively to my question about whether she generally was inhibited and unable to vent her anger. She told me that for years she had seen different internists for her heart disorder, neurologists for her migraine and the ear, nose and throat specialist for her feeling that something was stuck in her throat. None of the doctors had detected any organic pathology. Each had told her that as to their field of speciality she was healthy, i.e., she "had no disease." Apparently no one had inquired about her emotional state or had interpreted her functional symptoms in light of a psychobiological disorder: the constant swallowing of anger.

THE MEANING OF BODILY SYMPTOMS

The basis for the traditional physician's diagnosis was the patient's complaints. Some complaints inevitably pointed towards a particular emotional evaluation regardless of what complaints they were associated with; e.g., thoracic depression pointed towards the liver, and lumbago towards the kidney. Other complaints revealed their meaning only within a specific symptom cluster. There are two important differences in decision-making patterns between Chinese and Western medicine. First, somatic structure plays an inferior role in TCM. As we

will see, the organs named in the diagnoses must be understood as emotional metaphors. Second, the diagnosis is based on the pattern of somatic symptoms. The average symptom pattern of the patients in this study consisted of six symptoms.

All of the complaints obtained in the setting of this study could also have been obtained from Western patients. There were no culture-bound complaints. However, the meaning of these symptoms was quite specific to the Chinese context and to TCM. The following is my analysis of the meaning of some of the most important and most commonly presented complaints, derived from my observations.

The analysis focuses on 17 of the 32 most frequent complaints of the 106 patients in this study (the numbering follows the sequential order of Table I). A few symptoms that are quite common in Chinese patients, e.g., *tou zhong* (heaviness of the head), *wei xia chui* (gastroptosis), *tong jing* (dysmenorrhea) were presented only once or not at all during this study and are not included. Some of these symptoms are seen more often in other outpatient clinics, e.g., acupuncture. This study is just a beginning. One of the leading traditional textbooks on differential diagnosis lists almost 500 relevant symptoms (Zhao et al. 1984). Furthermore, this study does not include symptoms that refer to the correspondence of lung and grief. There were only two asthmatic patients in the group of 243. Further research is needed.

My analysis of meanings of symptoms is different at certain points from that in various TCM textbooks. One reason is the common difference between theory and clinical practice in medical sciences. TCM has an elaborate theoretical framework, e.g., the Theory of Five Phases. In this theory the heart corresponds with joy. During the early formative period of Chinese medical thought, desire was seen as one of the main pathogenic factors. In an extensive semantic network, joy corresponded with (sexual) desire, lapses of self-possession, outflow of vitality (loss of *qi* and semen), bodily depletion and thus opening of the body to disease-inducing external agents. This correspondence has been transmitted historically, and Chinese textbooks go to great pains to present actual case histories of the damage of the heart through joy. But it seems that nature resists meaningful thought if this is not based on meaningful bodily experiences: the heart that leaps joyfully in sexual desire reacts with illness not to joy but to anxiety; e.g., anxiety caused by trespassing of social taboos and sexual inhibitions.

Strong regional differences also account for some degree of variability. Today's TCM is a unified system with standard textbooks, but there surely exist local medical cultures.

1. Vertigo ('tou yun', 'tou hun')

Tou means "head," *yun* means "dizzy," and *hun* means "mixed," "confused." Patients often use *tou yun* and *tou hun* alternatively, although *tou hun* indicates a somewhat more serious condition. Vertigo is the most frequently cited complaint among Chinese patients worldwide. It must be interpreted within the potent cultural framework of social and individual balance and harmony. It serves as a metaphorical expression of physical as well as psychosocial disharmony, or loss of balance. As one's life should be led according to the concept of harmony, vertigo is viewed as a quite serious indicator of disease by Chinese patients: "There is a (health) problem that makes my head spin." In the theory of TCM, vertigo corresponds with the liver and the heart, as well as with the kidney. Thus, vertigo is not very specific. It is interpreted as a symptom of enraged anger (liver) or as an expression of anxiety (heart). In elderly patients, especially menopausal women, it is usually interpreted as a result of loss (deficiency) of kidney essence (life essence). The same holds true for young women after childbirth. If a middle-aged, married male suffers from vertigo the traditional doctor might suspect too much sexual intercourse; in young men, excessive masturbation.

During my first stay in China, from 1978 to 1980, vertigo posed many questions to my medical understanding. Only in a small number of cases was vertigo caused by hypertension, hypotension, or Menière Syndrome. I managed to grasp the meaning of this complaint through a peculiar coincidence. While riding a train a Chinese friend and I had eaten a lot of snacks that did not mix well. I suddenly suffered from nausea and realized that I was pressing the epigastric region with one hand. I was sure that I had strained my stomach. At the same moment my Chinese friend said that he was suffering from vertigo, and he seemed very concerned about it. I inquired about his perception several times. He insisted that he was suffering from vertigo and only after some time he remarked that something was wrong with his stomach. I tried also to experience vertigo, and actually found that this was not very difficult, because the nausea was associated with a feeling of unclarity or confusion in my head. Assuming that in both of us the identical pathophysiological process took place, we differed in our perception due to different contexts of cultural interpretation. I had immediately tried to localize the cause for the nausea in the stomach; it was in the stomach where the disorder took "place." My Chinese friend cared less for the cause and for the locus of attack but sensed a bodily imbalance and was engaged in evaluating its seriousness.

Vertigo might be interpreted as the most general indicator of any psychophysiological disharmony in Chinese patients. Vertigo is an indicator that the disorder is taken seriously. In the context of TCM, whether vertigo will be interpreted in an emotional or physiological sense depends on the pattern of

2. *Various Expressions of Anger* (*'sheng qi', 'pi qi bu hao', 'fa pi qi', 'huo qi da'*)

Chinese culture emphasizes inhibition of strong emotional expressions (Lin 1985). Little children are scolded by their mother for aggressive behavior (Bond and Hwang 1986). This traditional value system is in some degree of conflict with the finding of this study that anger was the only emotion that patients referred to on their own and talked about with little inhibition. Anger is also the emotion with the most extensive semantic network. We do not have sufficient data about the psychosocial situations which account for day-to-day frustrations and aggressiveness in present-day China to comprehend this obvious contradiction. One explanation might be that anger is considered *yang*, and is an outspoken male emotion. It also might refer to some aspects of revolutionary behavior during the last 40 years.

The Chinese concept of *qi* resembles the Greek concept of *pneuma* and the Indian *prana*. The air that we inhale is at the same time our life giving force. *Qi* is a monistic concept that transcends the modern notions of organic and inorganic, material and abstract, and psyche and soma (Ots 1987: 45). *Sheng qi* literally means "to give birth (rise) to *qi*"; its semantic meaning is "to get annoyed," or "to get angry." When a Chinese says *wo sheng qi le* (literally: I got angry), this does not mean that he was able to vent his anger but that the anger was kept inside. Some sayings in TCM give clues to the liver-anger correspondence: *gan zhu nu* (liver is the host of anger), *nu shang gan* (anger hurts the liver), and *gan xi tiao da* (the liver likes to expand). The latter statement actually must be read: "Anger likes to expand." If anger is not allowed to express itself, then liver-*qi* will lose its harmony (*gan qi bu he*), will become stagnant (*gan qi yu jie*) and eventually flow in perverted directions. The liver (anger) will attack other abdominal organs and cause discomfort. Duodenal ulcers, abdominal distention, cholelithiasis, cholecystitis, ulcerative colitis, and other abdominal irregularities are interpreted in this way. This condition which in the terminology of the theory of five phases is called *mu ke tu* (wood attacks earth), is also referred to in more somatic terms as *gan qi fan pi* (liver-*qi* attacks spleen), and *gan pi bu he* (liver and spleen don't harmonize). In this condition the *qi* of the attacked spleen/stomach flows in a perverted direction and causes belching, bitter

symptoms of uprising character (*nu ze qi shang* = literally: anger causes the liver-*qi* to go upward) such as hypertension, blurred vision, and migraine. These conditions are also called *gan feng* (*liver-wind*) or *gan yang shang kang* (liver-*yang* flares up). It may also cause belching, vomiting, globus hystericus, and the retrosternal globe. Interestingly, these four symptoms were interpreted by one of the traditional doctors as a symbolic attempt to vent anger verbally, but culturally transmitted norms of behavior prevented the patients from doing so; nervous vomiting, belching, the globus hystericus, and the retrosternal globe represent (in succession) increasing levels of anger repression. Interpretations are very graphic in this case: anger wants to rise and get outside, but it is concealed in the chest or the throat or leaves the mouth in a deformed way. In the explanatory model of TCM, the most serious form of anger turned inward occurs with ulcerative colitis.

Pi qi bu hao literally means "bad *qi* of spleen" and is associated with a bad-tempered, grumbling, fault-finding person. I asked many patients why this colloquial metaphor links anger with the spleen and not with the liver, but virtually no one knew an answer. *Pi qi bu hao* refers to the above mentioned TCM concept of "wood overcomes earth." In the context of *fa pi qi*, this means that somebody who has stored up his anger for a long time might suddenly fly into a rage by which he expels his splenetic *qi*: Anger corresponds with liver, but to vent one's anger is semantically expressed as a metaphor associated with the spleen. These two correspondences make clear that within Chinese cultural norms anger should be repressed. Rage takes place only after a longer period of repressing one's anger, which will travel from the liver to the spleen.

Huo qi da which literally means "big fire *qi*," refers to a person with an easily flaring temper. In this context, *huo* is understood as "liver-fire." *Huo qi da* is more respectable than *pi qi bu hao*, because it connotes a straightforward quality without incessant bad temper. It may describe a courageous male (hero) who flies into a rage when in conflict. This rage corresponds with liver/gallbladder (*ta ganzi da* = he is courageous; literally: he has a big gallbladder). In contrast, grumbling anger corresponds with the spleen (note the proximity of this concept to the Hippocratic notions of "choleric" and "melancholic"). *Pi qi bu hao* usually is associated with the female.

5. *Abdominal Discomfort* (*'wei tong', 'duzi tong', 'wei bing'*)

Wei tong (stomach ache), and *duzi tong* (belly ache) are used synonymously, since stomach is a metaphorical term for the whole abdomen. *Wei bing* (stomach disease) is a widespread affliction in China. In general, it is assumed that the stomach is affected when problems of any kind – e.g., pains, diarrhea – occur in the abdomen. With *wei kui yang*, however, it is usually not a stomach ulcer which is involved, but a duodenal ulcer. In Chinese society, the stomach is attributed a central position – similar to the concept of *hara* in Japan – so that even Chinese doctors of Western medicine assign priority to stomach pathologies. We saw several patients who had undergone stomach surgery in a Western medical clinic, only to find out during the operation – or even later – that they had been suffering from cholelithiasis, a diagnosis that they had already received from traditional physicians before. The following is an example

of the extent to which cultural expectations influenced the perception of the symptoms. When we were convinced that a patient who complained about stomach troubles actually suffered from a gall bladder disorder (cholelithiasis, cholecystitis), we asked her to close her eyes and tell us where she felt pain when we palpated. Whereas she had previously indicated that the epigastric angle was the locus of pain, she now indicated a point above the gallpole (see patient of case study No. 2).

Abdominal ailments were interpreted by the patients in a completely somatic manner. One of the most popular etiological statements referred to the poor quality of nutrition, especially during the years of the Cultural Revolution (Ots 1987). Intellectuals complained most about their misfortunes during those years when they were labeled "the stinking ninth brigade of the bourgeoisie." Among them, abdominal pains were something of a class-specific ailment. As a rule, they defined their complaints somatically, and only in discussions did they begin to trace back their ailment to the frequent ruminations associated with their misfortunes. In this context, the expression *chi ku* ("to eat bitterness") linked a somatic with an emotional understanding: a person suffers from ailments of the stomach because he eats (swallows) bitterness or bad food (insufficient nutrition). The twofold meaning of the term "to eat bitterness" enabled the patients to switch from psychosocial to physiological reasoning: "I have eaten much bitterness. Now, I suffer from stomach problems. How could I not worry? My worries make everything worse." I suggest that the high frequency of gastroduodenal disorders that is usually associated with eating and nutrition in China as well as Japan (Ohnuki-Tierney 1984) and probably also Korea is linked to the psychosomatic process of "stomaching one's anger," and thus to the traditional cultural norms of emotional repression.

7. Palpitations ('xin tiao', 'xin ji', 'xin huang')

All three terms refer to the physiological experience of palpitations. *Xin tiao* literally means "jumping heart" and etymologically bears no emotional connotation. *Xin ji* literally indicates the sensation of a palpitating and/or arrhythmic heart. It also carries an emotional connotation, as *ji* means "throb with terror." *Ji* also exists in the combination *jing ji* meaning "palpitate with terror." *Jing* means "fright, surprise, shock, alarm" and is referred to as one of the emotions of the kidney. *Xin huang* means "to be flustered," "to be nervous," "to become alarmed," and thus is primarily interpreted emotionally, but as this condition is usually accompanied by the sensation of palpitations, it also may refer to the palpitation itself. The usage of these last two terms differed from patient to patient and they were often used interchangeably. Still, *xin huang* expressed the most frightening experience of palpitation (see also "distressed heart"). Palpitations was one of the key cardinals of neurasthenia.

8. Thoracic Depression, Feeling of Pressure in the Chest ('xiong men', 'men qi')

Xiong means "chest," *men* means "tightly closed," "sealed," and "de-pressed" in the sense of the physical experience of a weight on the chest. *Men* in colloquial language also refers to an oppressive, low-pressure weather condition shortly before a thunderstorm. It can also refer to a social experience evaluated as dull and boring, such as a political lecture. It means the depressed emotion as well as the sensation that is caused by light forms of angina pectoris without the radiation of pain into the left arm. In the theory and practice of TCM thoracic depression corresponds with the liver, e.g., blocked anger. This correspondence is expressed in the metaphor of *men qi*, translated as "sulky." It refers to the blocked *qi* of the liver and describes the urge of the *qi* to emerge while sealed within the chest and causing pressure on the chest (see also "flank pain").

A linguistically identical term for pain and pressure in the chest and emotional distress is found in many cultures. In German the terms for depression as medical classification, or describing a mood, for angina pectoris, and for low-pressure weather condition all refer to the idiom of "pressure" as it is experienced in the chest: *Druck über dem Herzen; Druck auf der Brust; deprimiert sein; sich bedrückt fühlen; Tiefdruck (Wetter)*. The English term depression also derives from this physical experience. German, Turkish, and Afghan patients whom I saw in my practice referred to a related feeling of heaviness in the chest, "as if the heart is squeezed" (see also Good 1977; Good, Good and Moradi 1985; Kleinman 1986). German patients often describe their perception in the metaphor of a steel band tightened around their chest (like bands around a wooden wine barrel). German patients with anger-induced heaviness in the chest react positively to the popular German idiom "*Machen Sie Ihrem Ärger Luft*" which literally means "to exhale one's anger," an expression used for "speaking out." Thoracic depression has also been documented historically. Weiner (1986) cites William Harvey, who described a patient whose anger, grudge, and vengefulness induced extreme sensations of pressure over the heart and chest.

The character of *men* is written with a radical that represents the heart. Etymologically this does not necessarily mean, however, that this sensation refers to the heart. In Chinese writing the heart radical of a character indicates that this character refers to a broad range of meanings such as thinking, mind, conscience, moral nature, intention, idea, ambition, feeling, affect, or emotion. Six of the "seven emotions" of TCM corresponding with organs such as the liver, spleen, kidney and the lung are written with the heart radical. Interestingly, the Chinese character for the affect of joy (*xi*) representing the heart in the

quially used in the combination of *fan zao* (to be "agitated," "fidgety"). There is also the combination *fan men* (for *men* see "thoracic depression") which means to "be unhappy," "worried," referring to a combination of emotional distress of the heart and the liver. A distressed heart is most often accompanied by palpitation, increased dreaming and insomnia. These patients revealed various degrees of anxiety.

As the heart is considered the emperor among the internal organs and the seat of the mind and emotional control, the label of mental disorder is more easily applied to patients with a "distressed heart" than to withdrawn, introverted and depressive patients. Patients with "distressed heart" were very often labeled as neurasthenics. For the layman, this term does not indicate a mental disorder, but is usually understood somatically (Kleinman 1982, 1986). Patients felt exceptionally free to talk about their neurasthenia.

23. Globus Hystericus ('mei he qi')

Mei he qi literally means "plum pit-*qi*". It refers to the sensation of a plum pit stuck in the throat (choking sensation). Patients who reported this sensation constantly cleared their throats. TCM interprets the globus hystericus with uprising liver-*qi*. My teachers defined it as a condition between angry vomiting, belching, and the sensation of the retrosternal globe. The hysterical globe was interpreted by one of my teachers as an attempt to vent anger, but which gets stuck in the throat. (For further explanation see the meaning of various forms of anger.) Laymen usually did not know the term *mei he qi* and its correspondence with repressed anger. They thought that something was growing inside the throat, and consulted the Western ear-nose-throat specialist for such conditions.

25. Retrosternal Globe ('xin xia pi', 'xin xia pi ying', 'xin xia ni man')

These traditional Chinese medical terms describe the feeling of a lump in the chest right behind the sternum. In the absence of a layman's nosological expression to denote this condition, many patients referred to it as something that happened inside the abdomen, others to something inside the chest. The terms very graphically describe stuffiness, rigid or non-rigid, whether accompanied by belching and/or nausea or not, taking place below rather than inside the heart (*xin xia*). In Western terms it might be compared to the sensation of a lump in the diaphragmatic-gastric region that is typical in migraine patients. In migraine it is usually accompanied by nausea and precedes vomiting, and it is also relieved by vomiting. Whereas patients usually believed that they were afflicted with some gastric disease (e.g., cancer of the cardia) and underwent

several diagnostic procedures in Western clinics, TCM referred this sensation to the concept of blocked liver-*qi* and the "perverted flow of liver-*qi*" attacking spleen and stomach (*gan qi fan wei*), thus linking migraines with stagnant anger.

31. Numbness in the Four Extremities ('si zhi ma mu')

Si zhi are the four extremities. *Ma mu* means "apathetic" as well as "numb." Patients with this symptom experienced a somewhat paresthetic crawling sensation in their extremities which almost paralyzed them, although there existed no physiological paralysis. They felt unable to walk, work or to use their hands and very often exhibited depressive behavior. This sensation was associated with the spleen, which is responsible for the muscles. In general, the traditional doctors did not regard patients with this sensation to be depressive, even if their complaints were accompanied by other physical spleen correlates such as loss of strength and frigophobia. Their disorder was viewed instead as a loss of harmony of the normal digestive function of spleen/stomach. Only in our common discussions some of my teachers associated this symptom with a depressive mood (*you yu*).

32. Stiffness of the Neck, Neck Pain ('xiang jiang')

This symptom bears a unique meaning in the explanatory model of the traditional doctors. It serves as a differentiating criterion between physiological heart disease and syndromes of anxiety such as "distressed heart." If a patient, particularly a young one, complained about palpitations and insomnia, the doctor asked whether he also suffered from neck pain. If this was the case, the disorder was immediately interpreted as emotional. Laymen used to view neck pain in the same way as any other muscular tightness. But a change has taken place in this respect which might serve as an example for disease construction through technical innovation. Two years after this study I conducted research among healers and followers of *qigong* (Ots 1987). When interviewed about their illnesses, many of the patients stated that they were suffering from cervical osteophytes (*gu ci*). In most cases these were patients who also suffered from anxious heart syndromes. Usually they mentioned neurasthenia if they had received this diagnosis from a Western clinic to which they had turned. Their Western physicians ordered x-ray of the neck, and in the majority of cases, the radiologists detected osteophytes. These deformations of the vertebral bones are common in elderly patients, but do not necessarily cause discomfort. Yet, the physicians of Western medicine associated the pain with the radiological findings. Misdiagnoses of emotionally affected disorders by Western medicine

in China are quite common (Ots 1987). It seems that Chinese doctors of Western medicine have lost contact with their own medical tradition. Due to the continued prevailing belief in "scientism" in China, Western medicine in China is extremely reliant upon a biomedical point of view and almost totally disregards the old functional psychosomatic mode of viewing disease and illness. A meaning-centered interpretation of the lived-body has given way to a reductionist, structurally oriented understanding that acknowledges only facts that are measurable or visually identifiable (see also Xu 1985, on "minimal brain disorder").

INTERPRETATION

Porkert (1974) pointed out that in TCM terms such as "liver," "heart," and "spleen" do not mean the anatomical substrate, but relate to a certain pattern of functions he called "orb." In fact, this study demonstrates that the organ-term based nosology in TCM is a metaphor whose primary referent is not a particular organ but an emotion diagnosed via the patterns of somatic symptoms. Thus, TCM is built on a symptom language rather than on an organ language.

This study of 243 patients, of whom 106 were diagnosed as suffering from psychologically affected disorders, revealed a basic emotional dichotomy between the liver and the heart. More than two-thirds of all emotional disorders were associated with these two organs.

The Liver as Metaphor for Anger

Some 80 percent of the liver-related diagnoses referred to different degrees and forms of anger. The remaining twenty percent of liver-related diagnoses described primarily somatic lesions of the liver, for example, in hepatitis. Patients had experienced different forms of psychosocial stress, but social and cultural norms and circumstances did not permit them to react aggressively or to vent their anger. The repression of anger was expressed by a wide variety of somatic symptoms taking place in different regions of the body. Two main conditions were expressed in the terms of "liver attacking the spleen" and "liver-*yang* flaring up." Both were characterized by various degrees of self-directed aggression. "Liver-*yang* flaring up" must be interpreted as an attempt to vent anger. The pathodynamics of long term unresolved liver-anger points towards the spleen. A liver disorder might eventually become a spleen disorder; or, in other words, anger turned inward might cause depression. This Chinese experience resembles the still-dominant Western psychoanalytic hypothesis that views depression as anger turned against the self as a defense against a par-

ticular loss. This hypothesis has never received empirical confirmation (Kleinman 1986). In TCM, anger is also related to colon disorders, especially ulcerative colitis. Patients who suffered from these problems were not or were no longer aggressive, but they developed a style of behavior which might be characterized as "sublimated depression." They had "come to terms" with their depression by exhibiting a behavior of extreme tolerance. They had achieved social conformity by converting their emotions into a self-aggressive disease.

The Heart as Metaphor for Anxiety

Eighty-five percent of the heart patients suffered from anxiety, uncertainty, and fear. The remaining fifteen percent of the heart-related diagnoses indicated somatic heart disorders such as myocardial infarction and left heart insufficiency. Usually, some life-event implying a threat or insecurity was involved. In some cases, cadres who had gained their present position during the reign of the "Gang of Four" were now frightened because they had to pass newly introduced examinations. There were university students suffering from examination stress and persons who had been promoted to a position with more responsibility than they were confident they could assume. Marital problems were not cited as life-events causing health disorder. Most of these patients reported their emotional situation as *jinzhang*, meaning "anxious" and also "nervous."

When the diagnosis combined the heart with other organs, this indicated an aggravation of the emotional condition, a fact which is well documented in modern Chinese medical textbooks. The heart-liver combination resulted in only slight aggravations with such patients showing additional symptoms of anger. The heart-spleen combination indicates an overlap of anxiety and depressiveness. The heart-kidney combination in which heart symptoms appeared alongside sexual dysfunctions was considered to be most serious. This fact comes as no surprise since heart-kidney disorders stand for failures of the mind (heart) and of reproduction (kidney).

The few times when traditional doctors used the Western term neurasthenia, they referred to disorders of the heart.

The Spleen as Metaphor for Melancholia

Traditional diagnoses involving only the spleen revealed emotional significance in 28 percent of all spleen-related diagnoses. However, in diagnoses that combined the spleen with other organs, the emotional meaning increased in importance, approaching 100 percent in conjunction with the liver. The spleen

became involved when an emotionally affected disorder persisted over a long period of time without receiving adequate treatment. The liver (anger) was most frequently involved in such cases, with the heart (anxiety) next in frequency. There were no combinations between spleen and kidney. Kleinman (1986) reported on the overlap between hysteria and depression, and between anxiety disorders and depression in his 1980 sample of 100 Chinese psychiatric patients. If we hypothesize that hysteric behavior in the context of TCM would be classified as suppressed liver-anger, these findings are quite similar.

All patients whom I considered depressed had received a diagnosis in which the spleen was involved. The traditional doctors, on the other hand, did not characterize these patients as mentally suspect. Abdominal complaints are very common in China and are usually defined somatically in the sense that they are attributed to poor nutrition. I considered most patients of this type to be much more seriously disturbed than those patients labeled as "neurasthenics," but quiet and introverted patients fit the culturally transmitted value of harmony so well that they are not evaluated as suffering emotionally. These patients were the least likely to report their emotional situation as changed. A few admitted that they were *bu gaoxing* (unhappy). Depressed patients were the most likely to cry. As in the traditional medical systems of many other non-Western societies (Marsella 1978), depression does not exist as an ontologically or nosologically defined entity in TCM (see Tseng 1973).

The Kidney as Metaphor for a Decline of Vital Essence and a Decline of the Reproductive Forces

Kidney disorder means a loss of physical essence which occurs with aging. The kidney was involved in complaints of women who previously had given birth, and in menopausal women. Following the same concept, traditional doctors attribute kidney disorders to excessive sexual activity in men. In some men, heart-anxiety did not lead to spleen-depression, but to damage of the kidney-reproductive forces. In TCM theory, fear and fright are supposed to injure the kidneys (*kong ze qi xia* = literally: fright leads the kidney-*qi* down). Although this statement seems to be true in some cases, as illustrated by loose stools in a stress- and fearful situation, e.g., before an examination, its role in the disease/illness process is not yet clear. In this study most patients who were classified as suffering from a kidney disorder did not primarily suffer from fright. Their fright was culturally constructed by the specific semantic network of the kidney. Some of the kidney patients exemplified the way in which a culture-specific meaning could transform a relatively mild complaint into a serious illness.

The TCM concept of emotional and somatic relations reveals remarkable similarities to the concepts brought forth by such different physicians and researchers as Hippocrates, Cannon (1911, 1939, 1953), Wolff (1950, 1953), and Alexander and co-workers (1951, 1968), i.e., the sympathetic action of fight and flight (angry liver and the anxious heart) and the parasympathetic action of regression-withdrawal (melancholic spleen). In the Chinese context, liver-anger relates to culturally induced repression of anger. Inwardly directed anger might be interpreted as "hierarchical stress." Heart-anxiety might be interpreted as "dynamic stress": the quickening pace of life and processes of psychosocial transition. Spleen-melancholy relates, in part, to long-lasting, unresolved forms of both types of psychosocial distress.

In Chinese culture, the preoccupation with the somatic changes within the body leads to a one-sided layman's understanding of psychobiological correspondences. Whereas the majority of Chinese patients seem unaware of the emotional meanings of their complaints and focus on their somatic symptoms, experienced doctors of TCM are able to read the somatic symptoms as an emotional message. Due to the widespread mechanistic reading of dialectical materialism in China, the teaching of TCM during the last 40 years was extremely matter-oriented. Young graduates from colleges of TCM are usually just as unaware of the body-emotion correspondence of their medical heritage as are Chinese physicians of Western medicine.

CONCLUSION

One of my purposes in this article has been to reacquaint the reader – through numerous examples drawn from Chinese culture – with the lived body, or, as Merleau-Ponty (1962) phrased it, the "body in human experience," the "perceived body." Western philosophy has characteristically neglected the lived-body. Nietzsche asked whether philosophy had systematically misunderstood the body by dealing only with interpretations of it rather than with the body itself (Schipperges 1981: 15). The ethnographic method and cross-cultural perspective of anthropology may serve as a corrective to our "one-eyed view" (Schipperges 1981) of the body. Our awareness of the intentional and intelligent lived body, an awareness denied to us by our culturally "established misinterpretation of the body as a mere natural being" (Heidegger 1979: 99–100), "purged of spontaneity, willfulness and occult desires" (Leder 1984: 30), is the first step in collapsing the dichotomies of mind and body, subject and object. A phenomenological approach that takes the patient as subject must thus be based on the patient's self-reported perceptions that include his experienced somatic as well as his emotional changes. Alexander's (1951, 1968) concept of specificity might have developed along phenomenological lines, but he correlated "organic diseases" with "psychodynamic conflicts," unaware that these organ-based

disease entities were reductionist cultural constructs separate from the patient's subjective reality.

While reading the above examples, the reader may have experienced and recognized certain familiar bodily perceptions. Some might have seemed very unfamiliar. In describing the experienced meanings of a culture other than our own we find universal and culture-specifically shaped symptoms. Let us look at lumbago. This symptom is embedded in an impressive semantic network that seems to construct even palpitations. Could we find a better example of the culturally constructed body? But we can show that this network rests on nothing but primary bodily perceptions projected into the world as objects: the sensations of tension and pain over the lumbar region as perceived, e.g., after strong sexual arousal, after lengthy sexual intercourse, and, of course, in old age. What differs from culture to culture is the process of objectification; i.e., the interpretation of these perceptions. And what about palpitations and heart illness due to nocturnal ejaculation? Surely, it is the specific fear-inducing semantic network of semen-essence loss that leads to palpitations, but it does so in a mediated way, mediated by the body: regardless of what might be the cause for fear and anxiety in whatever situation and culture, the correspondence between anxiety and palpitation seems to be universal. This, of course, is nothing but a hypothesis and has to be investigated cross-culturally on a broader scale. Only a wealth of lived-body data can give us answers.

The approach to the body that emerges from traditional Chinese medicine is one at considerable odds with the body as conceptualized by Western culture and biomedicine. I do not argue that the Chinese approach to the body is more "real," but rather that it helps us to view the body in a more functional and pattern-oriented way. When we perceive and observe the lived body we must become aware of all its utterances, i.e., of its *gestalt*, if we want to go beyond reductionism.

In addition, this article is a contribution to the ongoing debate in psychosomatic medicine concerning the specificity of symptoms. Psychosomatic medicine has not fulfilled our expectations of it, and one reason might be that most scholars argue from the assumption that the human body possesses no intentionality, thus perpetuating the body-mind split. At present great changes are taking place in biomedicine. The findings of psychoneuroimmunology question the old mechanical view of the body. Psychoneuroimmunology "represents a much more differentiated, more finely tuned articulation of disease and healing processes, increasingly dissolving the three long-standing dualisms of mind and body, body and environment, individual and population. For the first time, medicine is equipped with a discourse capable of formulating very specific correlations between (i) the patient's bodily experienced meanings and (ii) conditions or states of the medical body, the body that figures in the research and clinical practices of medicine" (Levin and Solomon n.d.: 25).

Does this mean that there exists a human nature and not merely a human condition? I believe so. But I do not see the human body as opposed to the mind, nature as opposed to and separate from culture. We have to understand the body as "body-subject," consciousness in its bodily perceived mode.

Every new paradigm needs a new name. Levin and Solomon (n.d.: 24) speak of seven bodies in Western historical thought, the latest one to be called the "body of experienced meanings." However accurate this may be, it is too unwieldy to be easily integrated into general usage. What is needed is a one-word expression of body-mind unity. *Leib*, which is resistant to the polarization of meaning necessarily implied in any compound word based on "body" and "mind," and which is the historical North-European term denoting this unity, seems the appropriate choice.

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NOTES

1 According to the Oxford English Dictionary (1989), the present German term *Leib* and the present English term life are both derived from the Aryan term *leip*, *loip*, or *lip*. Other examples are Old English: *lif*, Old Frisian: *lif*, Old Saxon: *lif*, Old High German: *lib*, Middle High German: *lip*, Old Norse: *lif*, Old Teutonic: *libo*, and Swedish: *lif*. In most of these examples the term denotes simultaneously "life," "person," and "body."

2 This article does not deal with the basic problem inherent in the construct of psychosomatic diseases. Psychosomatic research has identified only a small number of disorders as psychosomatic, thus contradicting its own assumption that "mind" and "body" are one. Psychosomatic thought has thus not overcome the body-mind gap as well as the link between causality and temporality. Lipowski (1986) argues that the term "psychosomatic disorder" should no longer be used because it "tends to perpetuate the obsolete notion of psychogenesis, one incompatible with the doctrine of multicausality which constitutes a core assumption of psychosomatic medicine." Yet, this term is used here because it provided a basis for comparison with the Chinese concept of "Seven emotions causing disease."

3 The "Seven Emotions" and their corresponding five organs in traditional Chinese

theory are: liver-anger (*nu*), heart-joy (*xi*), spleen-worry (*si*), kidney-fear and fright (*kong, jing*), and lung-grief and sorrow (*you, bei*). I have pointed out in the text that there exist considerable differences between this over 2000-year-old theoretical framework and clinical reality.

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