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WEAK NERVES IN CHINA:
NEURASTHENIA-DEPRESSION CONTROVERSY AS A WINDOW ON PSYCHIATRIC
NOSOLOGY

BY

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DISSEYATION

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ABSTRACT

Although *shenjing shuairuo* (SJSR) has remained a salient clinical and cultural concept in China since the first decade of the twentieth century, in 1980 neurasthenia was removed from the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders*. This roughly coincided with the opening of China after Nixon’s famous visit, and for the first time in many years, Western academics were welcomed back into China to research and collaborate. Several publications arising from one such collaboration sparked what has become known as the neurasthenia-depression controversy and initiated a paradigm in cultural psychiatry termed the new cross-cultural psychiatry (NCCP). Almost without exception, research on SJSR has cited and relied upon the perspective and interpretation of writers situated within the paradigm of NCCP. Unfortunately, there has been no effort in the literature to make a comprehensive criticism of the predominant views of SJSR as they have been propagated over the past 40 years through NCCP writings. In this dissertation, I undertake this effort by first addressing the origins of neurasthenia in the West and then making a study of how SJSR came to be a salient category in China. After establishing this background, I attempt a comprehensive exegesis of the hegemonic efforts of Western psychiatry to frame SJSR within the NCCP and the responses of Chinese scholars to those efforts. In addition, I develop an explanation for how psychiatric distress can vary across cultures. I argue that culturally salient categories are conformed to consciously or unconsciously through a process of belief and expectation, and that codified experiences can be translated from the mind to the body and back again. I maintain that neurasthenia arose as a diagnostic category in the context of a long historical discourse of “nerves” and “nervousness,” but that SJSR became a salient conceptual category in the absence of any such historical discourse. As such, it became a temporally, geographically, and culturally specific mode of manifesting human distress and inner perturbation. SJSR will continue to defy attempts at reductionistic redefinition under the influence of American psychiatry, as it (and categories like it) serves an important function in capturing certain forms of human experience.
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Chapter 1: Introduction

“Our golden arches do not represent our most troubling impact on other cultures; rather, it is how we are flattening the landscape of the human psyche itself. We are the engaged in the grand project of Americanizing the world’s understanding of the human mind”.¹

In 1980 the American Psychiatric Association (APA) published the third edition of its clinical manual, The Diagnostic and Statistical Manual of Mental Disorders (DSM-III).² One of the many changes that made up the new version of the manual was the removal of the clinical category neurasthenia (nerve debility/nervous exhaustion), which had been a globally recognized disease category for over one hundred years. Both China and Japan had traditionally employed the category in their respective neuropsychiatric nosologies, but after 1980, Japan followed the United States and also abandoned shinkei suijyaku (神経衰弱) for having no validity as a disease concept.³ While in both the USA and Japan, the category has been subsumed under other clinical “entities”, the Chinese language equivalent, shenjing shuairuo is still a debated category that can be found on China’s public health websites, in its professional neurology and psychiatric literature, and in its diagnostic manual, CCMD-3 (Chinese Classification of Mental Disorders Version 3).⁴ Physicians in China (and the Indian subcontinent) have continued to make use of the category, though drastically less so, and it has wide popularity as a health concern among laypeople within China. Neurasthenia has also been retained in the World Health Organization’s publications of the International Classification of Diseases, in its current tenth edition (ICD-10) and with an eleventh in development.

Neurasthenia is increasingly rarely employed as a diagnostic category outside of China and India. This can probably be attributed to the global influence of the DSM, which moved beyond its previous abandonment of neurasthenia, reintroducing it as a cultural syndrome in 1994. A cultural index only appeared in the DSM in the 1990s, after nearly three decades of collaboration between anthropologists, psychiatrists, and other mental health researchers. In 1994 the APA

² Hereafter, DSM, with the edition listed either as a Roman numeral for I-IV or 5 for the most recent edition.
³ To state that neurasthenia was abandoned for having no validity as a disease construct is somewhat of an overstatement. This subject is briefly touched upon in the concluding chapter.
⁴ 中华医学会精神科分会. 中国精神障碍分类与诊断标准. vol. 3版 (CCMD-3) (济南: 山东科学技术出版社, 2001).
published DSM-IV, which included a section titled, “Outline for Cultural Formulation and Glossary of Culture-Bound Syndromes” (p. 843). Listed among these “culture-bound syndromes” is the following:

*Shenjing shuairuo* (neurasthenia): In China, a condition characterized by physical and mental fatigue, dizziness, headaches, other pains, concentration difficulties, sleep disturbance, and memory loss. Other symptoms include gastrointestinal problems, sexual dysfunction, irritability, excitability, and various signs suggesting disturbances of the autonomic nervous system. In many cases, the symptoms would meet the criteria for a DSM-IV mood or anxiety disorder. This diagnosis is included in the Chinese classification of mental disorders, second edition. (CCMD-2).\(^5\)

By situating it as a “locality-specific pattern of aberrant behavior and troubling experience” (DSM-IV, p. 848), the APA defines neurasthenia as a culture-bound syndrome that belongs to the Chinese experience, which continues with both the DSM-IV Text Revision and the 2013 publication of DSM-5. This has raised questions about whether the “real” underlying problem that patients experience is better described as a form of mood disorder, anxiety disorder, somatization (躯体化), or if there are instances of SJSR that simply cannot be explained by any other category of experience. Whatever the case, the last two versions of the DSM have relegated the category to the periphery as a “local” issue. Nevertheless, *shenjing shuairuo* (hereafter abbreviated SJSR) has historically been very “real” to Chinese people and has entered into the lexicon of all native Chinese speakers. References to the illness in literature and magazines, webpages, and online shopping websites are numerous, and a simple web-search of the Chinese term yields a seemingly infinite array of information from countless perspectives.

Professionally, in the decades approaching the turn of the twenty-first century, SJSR is claimed to account for up to half of all psychiatric diagnoses in China, and some Chinese neurologists and psychiatrists continue to insist that it is not merely a disorder of somatization, but a valid clinical category that may or may not have a clear correlate in mainstream Euro-American experience. It can be given as an account for undesirable behaviors, failure at work or school, difficulties in the home, and other functional impairments of daily life. Self-help instruction continues to be published on the topic as it has since the final decade of the nineteenth century; in

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fact, such material is more plenteous today. Medicines of all kinds are still on offer for those who might have developed the disorder. Furthermore, Chinese researchers continue to publish scientific papers based on neuroimaging, nerve conduction, and other methodologies in order to argue for the validity of this clinical category or for the purpose of finding effective treatment. A search for the term 神經衰弱 in the Chinese academic database, CNKI, from 1990 to the present yields over 6,000 articles across a variety of journals, ranging from Western biomedicine to traditional Chinese medicine approaches. In 2017 alone, there were over 1,500 such articles. For example, in March of 2017 The Journal of Clinical Medical Literature published an article titled, “Study on the changes of serum cortisol and high sensitivity C-reactive protein in elderly patients with neurasthenia”. In July of 2017, Cardiovascular Disease Journal of Integrated Traditional Chinese and Western Medicine published a rather different approach in the article, “Anshen-bunao ye combined with oryzanol for the treatment of neurasthenia patients”. These two recent articles serve to show the disparate approaches to SJSR today. Serum cortisol and CRP are two very common clinical variables that a contemporary psychiatrist might find valuable when assessing a patient in an American hospital. Anshen-bunao ye, on the other hand, is a tonic remedy in China that contains deer antler, licorice root, ginger, and other ingredients. It can be readily bought in China or online, and it is packaged professionally as shown below in Figure 1 below. It is taken orally, as is “oryzanol”, which is a mixture of rice oil and other plant sterols.

Modern approaches of clinical chemistry are being employed alongside other eclectic methodologies in attempts further to delineate the meaning and management of SJSR as a clinical category. The subject of SJSR continues to be vast and carries implications for psychiatry in a global arena as well as for China’s continued engagement with the world in fields like medicine.

6 CNKI (China National Knowledge Information; 中国知网). This national information platform led by Tsinghua University and supported by the PRC Ministry of Education and Ministry of Science includes the database China Academic Journals Full-Text Database.
9 “安神补脑液_互动百科,” accessed December 8, 2017, http://www.baike.com/wiki/%E5%AE%89%E7%83%B6%E8%9C%A1%E5%88%84%E8%84%91%E6%B6%B2.
I have been thinking and reading about SJSR and neurasthenia for only fifteen years, which began when I was first living in Taiwan in the early 2000s.\textsuperscript{11} Since that time, I have realized that one can spend an entire lifetime examining the topic as it pertains even to just one location, at just one year in history. It may be for that reason that I have begun to abstract how I think about the category by alternately expanding and contracting the focus of my inquiry. As this is a dissertation in the field of East Asian studies, I do not address the Indian literature. However, since I am a physician and have a particular interest in cultural psychiatry, I approach SJSR from a multi-disciplinary perspective that includes anthropology, psychiatry, history, sociology, and philosophy, as indicated in the next sections. I am reminded of a 2011 book edited by Arthur Kleinman et al. titled, \textit{Deep China: The Moral Life of the Person: What Anthropology and Psychiatry Tell Us about China Today}.\textsuperscript{12} My own project might well be titled, \textit{What China and SJSR Can Tell Us about Anthropology and Psychiatry Today}. An examination of SJSR raises serious questions about the impact of Western psychiatry on the rest of the world, which has been a matter of concern for critical literature since Foucault. Additionally, SJSR can push us to reconsider the ontology of mental illnesses as well as the mind-body problem in both philosophy and neuroscience.\textsuperscript{13} I will return to these issues throughout this project. Presently, by way of further introduction, let me attempt to frame the questions I hope to address over the course of this dissertation.

\textsuperscript{11} I mention this timeframe only to acknowledge that this is less than half of the time that some of the thinkers who are cited in this work have spent studying this subject.


\textsuperscript{13} By “us” I am referring to Western intellectuals, researchers, physicians, and others who engage questions that arise throughout this project.
1.1 Questions and Their Contexts

Not only is the Chinese-language literature since the 1990s plenteous, English-language writing about SJSR could now amass copious volumes. These range from poorly written and unrigorous regurgitations of other authors’ claims, to well-thought-out and diligent efforts. One example of the more rigorous attempts to understand the category is a paper of Hugh Shapiro’s for “Symposium on the History of Disease” at the Academia Sinica. In “Neurasthenia and the assimilation of nerves into China”, Shapiro rightly claims that “psychiatry and medical anthropology have produced the most serious analyses of Shenjing Shuairuo”. 14 From among those literatures, Shapiro organizes seven categories of explanation raised to account for the very “ordinariness” 15 and taken-for-granted nature of SJSR as a once-imported category in China. His “dominant explanations” are listed here with the addition of my own brief explanations of each category: 16

1) Somatization: “the expression of personal and social distress in an idiom of bodily complaints and medical help seeking”. 17 This view has dominated cultural psychiatry and will be the subject of much of the latter half of this project.

2) Euphemistic function: diagnoses such as schizophrenia can be burdensome and stigmatizing, whereas SJSR is less stigmatizing and less socially threatening. This view is intimately related to somatization, and will reappear frequently.

3) Desirable sick role: SJSR is conceptually related to overwork, which frames the diagnosis in a possibly favorable light and entitles the sufferer to certain privileges.

4) Physician/patient rapport: SJSR is a familiar and non-threatening concept. Other diagnostic labels might lead to patient non-cooperation or loss to follow-up.

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15 Shapiro refers to the everyday, commonplace knowledge of SJSR among Chinese people as “striking ordinariness”. Ibid., 5.
16 For each category, Shapiro offers a corroborating citation which I will not also cite as there are numerous sources of such corroboration. I accept his categories as given. For his citations, see his paper “Neurasthenia and the assimilation of nerves into China”. If I include a quotation from another source, it will be cited below.
5) **Self-help:** patients are more likely to seek treatment when the illness considered is neurasthenia, as opposed to some other more stigmatizing category.

6) **Status:** The SJSR label has been fashionable in certain times and places.

7) **Nosological soundness:** SJSR describes a form of experience not captured with other categories. This is the most controversial of views regarding SJSR, and it has at times constituted a position of resistance against the influence of Western psychiatry in its apparent effort to re-define the meaning of SJSR in its Chinese context.

Shapiro quickly gets bogged down in a historical question, “examining the conceptualization of first systematic translation(s) of nerves into China”. He then finds himself grappling with classical Chinese medical theories in an attempt to understand what indigenous categories were in place to make the foreign import suitable for domestication. Before taking that direction, however, he does spend five and a half pages discussing “neurasthenia and politics” from what might be viewed as the perspectives of *euphemistic function* and *self-help*. (A repackaging of his discussion can be found in Kleinman and Lee and is addressed in later chapters.) He also spends just over three pages suggesting that neurasthenia is related to “being modern”, which does not fit well into any dominant explanation above, but which I reinterpret under an altered form of dominant explanation number six, *status*, in my third chapter. Before long, Shapiro’s original question of “how should we understand the popularity of neurasthenia in twentieth-century China” becomes somewhat obscured by these otherwise very important and fascinating lines of inquiry. His original question is just one way to approach the more basic question motivating my own inquiry, which I will now try to clarify.

My aim in this dissertation is to answer the broad but basic questions:

What are we talking about when we make reference to *shenjing shuairuo*, and how is its meaning contested by interested parties?

On the face of it, these seem very simple questions. It should be recognized that, though perhaps overly broad, they necessarily entail incursions into multiple branches of inquiry, making them far

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18 Shapiro, “Neurasthenia and the Assimilation of Nerves into China,” 16. This definition serves here, but there are numerous variations of it that appear in Kleinman and will arise again in the next chapter.


20 Shapiro, “Neurasthenia and the Assimilation of Nerves into China,” 2.
from simple. First, SJSR is a term in the Chinese language, which makes explicit the need to engage a variety of Chinese language materials that also refer to the term and often take it for granted. Second, SJSR is an official psychiatric category, which necessitates engagement with psychiatric literature as well as medical anthropology. In combination, these lines of thinking are what make up cultural-psychiatry as an academic discipline. Third, for better or worse, thinking about forms of human experience variously labeled disordered, ill, psychiatric, or diseased raises questions about the relationship between the mind and the body. For instance, SJSR is a formal category labeled “mental disorder” in both the CCMD and the ICD. In the twenty-first century, this label raises philosophical questions about mind-body dualism, and whether a given psychiatric disorder is ultimately a brain disorder. Or to put it another way: are mental states reducible to brain states, thereby necessitating the conclusion that mental disorder is ultimately brain disorder?

While this last question may seem very far afield from the main question I aim to address, and far afield from East Asian studies particularly, careful consideration will show that one very important aspect of my intended question cannot be answered without some recognition of the mind-body question. To illustrate this, let me recount part of my recent conversation with a professor of psychiatry at a well-known university on the east coast of the USA. The professor asked:

Aren’t we treating a diseased organ? Aren’t psychiatric illnesses disorders of the brain? If my patient is human and the Chinese patient is human, should not the disorders of the brain be the same here as they are there? How could there be a brain disorder that only occurred in the brains of people from that location?

His question is a fascinating one. The obvious implication is that, since we are all human, a particular label referring to mental disorder in one locale must correspond to the same disorder in another locale, even if they are being labeled differently. I do not agree. All cultural experiences are mediated by nervous systems. That is to say, every experience supervenes on brain states, and there is no reason to think that people with different cultural and linguistic backgrounds share

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21 Let me make this clear with further questioning. What are we referring to when we make reference to the formal diagnostic term of a mental illness, which is also a term appropriated by countless people who feel they have a debilitating illness? Does it make reference to an illness with respect to a mental state or a brain state? Is there a difference? I intend to address this as a theoretical problem later in this dissertation. It is a question that cannot go unanswered by those working in cross-cultural psychiatry, as I recently found out. Furthermore, I believe how we answer the question can go a long way towards explaining how Chinese people have historically claimed a clinical category that many believe is valid with respect to Chinese experience.
precisely the same brain-states. There may very well be particular brain-states at the micro-
physical level that are unavailable to me as a result of my not being fluent with or residing in a
particular cultural/linguistic milieu. The possibility of such differences has far-reaching
consequences for how mental disorders are viewed cross-culturally and requires greater rigor and
sensitivity.

Returning to my general questions, reference to SJSR is something that has a historical first
occurrence. Answering my question does not require, à la Shapiro’s efforts, that I pinpoint the
exact first occurrence of the term in Chinese, although I look at the matter briefly in a later chapter.
In order to answer my question, however, it is necessary to make efforts at understanding when
and how SJSR becomes popular in the twentieth century. Part of this process requires establishing
a conceptual framework for understanding nerves, neurasthenia, and nervous discourse in Western
societies prior to and leading toward their introduction into Japan and China. This is the subject of
Chapter 2. Most writing on SJSR addresses this in only a cursory manner, and I attempt to provide
the reader with a fuller account of this background. Once there is some understanding of the
Western history, however, some cultural theorizing is necessary for any attempt to explain how
SJSR became a meaningful category of experience in China. This I attempt in Chapter 3. As with
all theorizing, conclusions and implications can be debated, and my conclusions in this project are
not reliant on my conclusions in that single chapter. Over the subsequent two chapters, I will
provide the reader with the most influential interpretations of the Chinese experience of SJSR that
have arisen from the literatures of anthropology and cultural psychiatry (hereafter referred to as
ACP). These professional interpretations have shaped the definition of SJSR in the cultural
appendices of DSM-IV and DSM-5, and have framed the view of how Chinese experience SJSR
for the countless psychiatrists around the globe who use the DSM. It has also caused pushback
from Chinese researchers who believe SJSR is something other than what it has been framed to be
by their Western colleagues. These considerations facilitate a theoretical model for cultural
psychiatry that I find helpful when thinking about how psychiatric phenomenology changes

22 Charles M. Olbert and Gary J. Gala, “Supervenience and Psychiatry: Are Mental Disorders Brain Disorders?,”
Journal of Theoretical and Philosophical Psychology 35, no. 4 (November 2015): 203–19,
https://doi.org/10.1037/teo0000023. I think it should be uncontroversial that the microphysical brain states that
correspond with language production in Chinese are not equivalent microphysical states that occur with language
production in English. They may be analogous, but it does not seem reasonable to argue that they are equivalent
states at the micro level.
temporally and geographically. For the sake of clarity, I conclude this section with a summary of some of the questions that will be the focus of the individual chapters that follow.

Chapter 2: Before being translated into Chinese language and geography, what was the understanding of neurasthenia in the parts of the world where the term originated, namely Europe and the USA? Was there a discourse of nerves there? What did it mean to speak about nerves and weak nerves in American and European contexts?

Chapter 3: What do we know about the introduction of neurasthenia into Japan and then China? How might its popular reception be interpreted? What was the popular understanding of SJSR as evinced by the readily available sources of public information?

Chapter 4: During its inception in the 1970s and 80s, how did the alliance between anthropology and psychiatry conceptualize SJSR? Given that ACP have produced the most serious analyses of SJSR, what influential interpretations, consensuses, or conclusions did the fields produce in their first decade of inquiry? How did Chinese psychiatrists respond to the ACP model of SJSR?

Chapter 5: Once established, how did ACP sustain a research paradigm over the ensuing two decades? How was it employed by various researchers? How did Chinese psychiatrists respond?

Chapter 6: In the final chapter, a few questions will remain that will point to a conclusion for the project. After the first decade of the twenty-first century, how has somatization continued to be a subject of inquiry? What types of claims are being made in the twenty-first century by those who can be considered heirs of the interpretations presented in Chapters 4 and 5? Can we find phenomena analogous to SJSR in East Asia today? How might current Japanese uses of dysautonomia discourse influence our view of SJSR and somatization? What about the mind-body problem? Can neuroscience offer any help to the future of cultural psychiatry?

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23 There are a few reasons for choosing to separate Chapters 4 and 5 in this chronological manner. One is that from the original publications in ACP there were about ten years of settling-in time. Also, the decades closely follow the publication of DSM editions. DSM-III was published in 1980; DSM-III-Revised came out in 1987. DSM-IV was published in 1994, with its revisions in 2000. DSM-5 was published in 2013.

24 Dysautonomia is translated as Jiritsu shinkei shicchou shou (自律神経失調症; じりつしんけいしっちょうしょう)
1.2 Theoretical Considerations

This work begins with a quotation from Ethan Watters for a number of reasons. First, I have to admit that I am partial to the line of argumentation that Watters presents in his book, *Crazy Like Us*, and my overall thesis in this dissertation is very close to the idea that he is describing in the two sentences quoted above. Watters, whose wife is a psychiatrist, takes the reader through several examples of psychiatric disorders as defined in the DSM, and he attempts to show that their rising prevalence and incidence (of diagnosis or treatment) in specific countries outside the United States is directly related to their professional introduction into those countries. However, he denies that this occurrence is merely one of increasing recognition. Rather, he believes that the situation is better explained by another type of phenomenon that I prefer to describe as follows: human distress, of the type we call “psychiatric”, continually converges toward a homogeneity as American forms of any given category are exported globally. What this means and how it occurs will be discussed in more detail throughout these chapters as I specifically focus on neurasthenia and its Chinese language equivalent. To foreshadow, I consider SJSR to be an example of this on more than one occasion.

Second, Watters’ quotation reminds us that there is always the opposing influence of local culture acting as a force that resists, or at least modifies, conceptual categories to fit local needs. Returning to the quotation for the sake of demonstration, we might consider momentarily the hegemonic influence that the golden arches have played on the world scene, despite Watters’ downplaying of them. Visiting the golden arches in Taipei, Kaohsiung, Tokyo, Yokohama, Beijing, Shanghai, Xi’an, Hong Kong, and other places, one finds that the customer can order a sandwich with a rice patty instead of a bun, and since 2014 one can even order a “black squid ink burger”.

25 Take as an example the incidence of treated ADHD in Taiwan from 1999–2005. Huang et al. found that “there was a significant increase in the treated prevalence rate of ADHD during the study period, from 64.65 per 100,000 in 2000 to 145.40 per 100,000 in 2005 (p = .001). An increase in the treated incidence rate of ADHD, from 44.67 per 100,000 in 2000 to 81.20 per 100,000 in 2005, was also observed (p = .013)”. The argument from recognition claims that ADHD is just being recognized more, therefore driving up these numbers. Some suspect, however, that the introduction and popularization of ADHD as a category leads to an effect whereby people populate the category. It is difficult to determine when recognition is the source of epidemiologic changes as opposed to other effects of constructed categories. More is said on this later. For Huang’s study see: Huang, Charles Lung-Cheng, Chin-Chen Chu, Tain-Junn Cheng, and Shih-Feng Weng, ‘Epidemiology of Treated Attention-Deficit/Hyperactivity Disorder (ADHD) across the Lifespan in Taiwan: A Nationwide Population-Based Longitudinal Study’, PloS One, 9 (2014), e95014.
I take this as an example of the molding of the “golden arches” to fit the local, which is something that likely occurs through a give-and-take of local demand and clever marketing. The Japanese name of the sandwich is *ika-sumi baagaa* (鰻黒バーガー) and is usually written in katakana (イカスミバーガー). This is one of the better efforts to create “a culturally specific entity that integrates conceptual categories of traditional Japanese culinary art (*ika-sumi*) with the Western category of burger”.

One need not enter into a discussion of John Montagu, Fourth Earl of Sandwich, and the etymology or history of sandwiches in order to understand that the sandwich as it appears in that chain restaurant is a Western import that has taken on local flair. Sandwiches, mass-produced and listed on a menu, were institutionalized by the chain restaurant, and the customers got that first. The squid ink burger is a later consequence. An imported concept is the supraordinate category that is antecedent to its local embrace. The difficulty here lies in trying to understand what is the supraordinate and universal category behind reference to any phenomenon we might refer to as psychiatric. With respect to SJSR, it has always been premature to conclude that Chinese people “somatize” their “depression” and therefore have historically found SJSR to be a useful category or label, because both SJSR and depression, as conceptualized by the field of psychiatry, are imports. Given Watters’ analogy, the golden arches phenomenon may equally apply to the human psyche and what we might call the global “McDonaldization” of psychiatry. It should be predicted that at a given period of time, SJSR rates, and at another time depression rates, like burger consumption, should soar in China as each in turn becomes an increasingly available category of experience.

What is the point of all this? The Americanization, or Westernization, process is not undone by the process of indigenization that gives rise to the squid ink burger. Nor does recognition of the locally specific nature of the squid ink burger help us get at what the Japanese are “really” buying when they go to the golden arches. Rather, the squid ink burger brings into focus the imported character of the golden arches in the first place. This is, of course, only an analogy that I am using to link Watters’ point and my own topic. Writing in 2010, Watters attempts to tackle a concrete category. He tells us that “in the past two decades, for instance, eating disorders have risen in Hong


27 I am using the first sentence of the glossary of cultural concepts of disease in DSM-5 for Shenjing shuairuo: “Shenjing shuairuo is a cultural syndrome that integrates conceptual categories of traditional Chinese medicine with the Western diagnosis of neurasthenia”. See DSM-5, 836–37.
Kong and are now spreading to inland China”. What is the cause of the rise? Is disordered eating the consequence of imported norms of body image and beauty from the USA? He elaborates in a later chapter with the claim that the rise of anorexia in East Asia is a result of the popularizing of the category itself both among the professional community and the lay public. This amounts to a psychiatric version of, “if you build it, they will come”. This is a very serious claim, and I suggest that the reader look at his book carefully, as his other examples help make his case.

For my own part, I began studying anorexia in East Asia in 2007, three years before Watters’ book was published. At the time, I also came to the conclusion that anorexia was occurring as a consequence of its professional and lay introduction into Asian societies. However, I thought that it was unreasonable to demand, as a criterion for diagnosis, that the patient have an “intense fear of gaining weight or becoming fat, even though underweight”, especially in the context of rural Taiwan. By the time DSM-5 was published, cultural and gender research had demonstrated that alternative rationales for food refusal exist around the globe, and fear of gaining weight was removed as a necessary condition for the diagnosis. However, if Watters’ view is right, in the next ten years, East Asian patients with anorexia will look very similar to the average American patient, whereas this appears not to have been the case in years past. In other words, over time, most patients will likely demonstrate a “fear of gaining weight”. If this does occur, there will be researchers from various orientations arguing that the homogeneity across cultures is evidence of the underlying universality of the phenomenon in question. Others will see the social construction of a category that has slowly became populated. By analogy, there may be as many cultural manifestations of food refusal as there are varieties of burger; yet, those varieties are dependent on the introduction of the initial category. In like manner, we may see a time in China when “depression” as described in the DSM is more common than SJSR as defined in the CCMD. I do

28 Watters, Crazy like Us, 2.
not believe, however, that this would demonstrate that past SJSR patients were actually depressed. Let us consider another example from the United States to clarify what I am suggesting.

While recently perusing a web forum for discussions among young psychiatrists, I ran across this complaint:

I spent a year after residency working locums jobs in 3 different areas of the country, before taking a permanent job this past summer in yet another area. One thing I noticed is that there seem to be problems/complaints that are more common in some areas than others. Each locale had sort of its own ‘classic’ issue. And where I am now, it seems to be adults wanting to get diagnosed with ADHD for the first time in adulthood . . . I have a hard-enough time believing in childhood ADHD, but in residency I got through the mandatory rotations in child/adolescent (psychiatry) by keeping my head down, smiling and nodding, and doing what the attendings said. I did not expect this to follow me into the adult population.32

The thread continued with some discussion until one of the contributors opined in this fashion:

You might not be aware, but there was a flood of news reporting on adult ADHD in the last year or so. A lot of information disseminated about how it has different symptoms than classic ADHD . . . It seems like it's the medical community leading patients who then surprise another part of the medical community.33

The last comment above implies that patients are presenting in the clinic with a list of symptoms/complaints that only arose after the patient learned of the possibility of such a diagnosis from the interaction between the medical community and popular media. In other words, there is something going on in the culture that makes possible or draws a connecting framework around a certain type of experience. This may be true whether it is a newly recognized phenomenon like adult ADHD, increase in ADHD treatment in Taiwan, a rise in diagnosis of anorexia nervosa in Taiwan, or the rise in depression at a particular period in Chinese history. How could it be the case that aspects of society and culture give rise to phenomena referred to as psychiatric? It is necessary to make a serious effort at addressing this question before proceeding any further.

33 Ibid.
1.3 How Does Culture Shape or Give Rise to Phenomena Referred to as Psychiatric?

To begin to answer this question, several theoretical problems need to be addressed. For example, it is necessary first to clarify what is meant by the term “culture”, a problem about which no small amount of ink has been spilt. More importantly, the concept of “psychiatric disorder” has to be approached in a way that makes clear the presuppositions that must be admitted in order for such a question to be asked in the first place. This latter problem is at the heart of nearly all inquiry in the fields of anthropological psychology, psychological anthropology, and cultural psychiatry. It has also been the cause of great debate from the anti-psychiatry movement (Szasz) and social science critiques of psychiatry (Horowitz, Hacking, etc.).

Therefore, I divide this theoretical discussion into six sub-sections. I begin by briefly defining what I mean by the term culture. Without spending time to work through the details of a theory on culture, I merely posit a generally acceptable position from which to proceed. In the second section, I outline some of the philosophical problems requiring consideration for a meaningful use of the term “psychiatric disorder”. This includes a short discussion of the ontological and epistemological issues that underlie the main question posed here. Only then do I attempt, in the third section, to address the role of culture in shaping those phenomena normally classified and handled by the discipline of psychiatry. This requires a discussion of the notion of “idioms of distress” and the idea of a “cultural symptom pool”, Sections 4 and 5 respectively. In the sixth section, a brief summary concludes the theoretical section of this chapter.

1.3.1 Culture

Although there have been numerous workings and re-workings of what is meant by the term “culture”, it is safe to say that most can be summarized or otherwise embodied in the explanation offered by Clifford Geertz in his 1973 text, The Interpretation of Cultures. There he writes that culture can be described as “an historically transmitted pattern of meanings embodied in symbols, a system of inherited conceptions expressed in symbolic forms by means of which men communicate, perpetuate, and develop their knowledge about and their attitudes toward life”. 34

Since Geertz offered this anthropological definition, understandings of culture have broadened. Ironically, even the highly criticized publications of the American Psychiatric

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34 Clifford Geertz, The Interpretation of Cultures: Selected Essays (Basic Books, 1973), 89.
Association have attempted to develop a sophisticated conception of culture. The latest volume of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-V)* has explained it as follows:

Culture refers to systems of knowledge, concepts, rules, and practices that are learned and transmitted across generations. Culture includes language, religion and spirituality, family structures, life-cycle stages, ceremonial rituals, and customs, as well as moral and legal systems. Cultures are open, dynamic systems that undergo continuous change over time; in the contemporary world, most individuals and groups are exposed to multiple cultures, which they use to fashion their own identities and make sense of experience.\(^{35}\)

By approaching the concept in this manner we can conclude that human beings living within any given society or community employ culture in various ways in order conceptually to understand and organize their lives. On this definition, we can eschew assuming the existence of such monolithic cultures as “Chinese Culture”, “Indian Culture”, or “American Culture”. Rather, it is understood that there may be numerous “Chinese cultures”, or others, that constitute and are constituted by the life-worlds of the people in question. Such an understanding helps avoid the errors of either essentialization or attribution of special status to some overarching order. Nevertheless, there may be some conceptualizations about life experience that appear to group geographically, historically, and/or linguistically. These are the kinds of cultural conceptualizations that are of interest when discussing the role of culture in shaping psychiatric phenomena.

### 1.3.2 Ontic vs. Epistemic Understandings of Psychiatric Disorder

Using the term “psychiatric disorder” normally implies some presuppositions about the world. This is the case because speaking about “disorder” already situates the term within the realm of a specific medical discipline that is largely traceable to eighteenth and nineteenth century Europe and the United States. Psychiatric disorders are the “object” of medical inquiry, diagnosis, and treatment, and as such, they are given ontological status consonant with the notion of “disease entities” studied by psychopathology. In the context of cultural influences on the psychiatric, however, it may be necessary to de-medicalize the subject of inquiry to some extent in order not to assume the ontology of scientific realism from the outset of inquiry.

Horacio Fabrega suggested that the term “psychiatric condition” suits this purpose. In his

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\(^{35}\) DSM-5, 749.
work on the history of mental illness in India, he submitted that emotional and behavioral disaffections or disruptions in habit-patterns or social conduct fit the meaning of psychiatric condition when they fulfill four criteria. These are: 1) persistence over time rather than situational or fleeting, 2) interruption of the course of one’s life, 3) production of psychological and bodily distress, including visceral/somatic complaints, and 4) disruption associated with significant changes in functioning noticeable from within the social and cultural space of the persons involved. These four criteria constitute the manner in which one can be said to “suffer” from a “condition.”

Fabrega’s use of the term condition rather than disorder in this case seems to stem from the desire to address what he sees as universal, human phenomena without imposing a specific epistemological system or nosology onto them. In other words, he wants an etic ontology regarding phenomena of psychiatric interest while maintaining the possibility for an emic epistemology of their meaning. He accomplishes this far better when he uses the model of “Human Behavioral Breakdown” (HBB), which does not depend on either disorder or condition as a descriptive term.

There is now a large body of evidence suggesting that in all societies and communities throughout human history there have been types of behavior that persist over time and are understood by others in the community as constitutive of breakdown (as something having gone awry). This need not always carry a moral, judgmental, or normative evaluation. Rather, it may merely indicate that the behavioral disruption leads to the inability to perform some task as usual, or it may indicate some other significant loss of functioning recognizable by others. The range of descriptions referred to in contemporary clinical psychiatry as schizophrenia happens to be one candidate of HBB that appears to occur across time and space, though course and outcome of the experience seem to vary by culture.

If the phenomena of psychiatric interest are re-conceptualized as HBB, then it is possible to reconsider what is meant by disorder and pathology in a broad sense. In this way, disorder becomes an instance of dis-order, and pathology takes on the etymological sense of pathos as

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38 Fabrega argues that this is also true in communities of non-human primates. He wrote a book length study on the issue called *Origins of Psychopathology*.
suffering. A comparative researcher (e.g., a cultural psychiatrist) can look for instances of HBB that appear to share an analogical relationship, if not an equative one, with the phenomena that are subsumed under certain psychiatric nosologies without requiring absolute equivalence in all aspects of experience. Rather than assign a privileged status to the context that gave rise to the conception of psychiatric disorder (namely, nineteenth-century Euro-American medicine), this orientation allows for the understanding that contemporary psychiatry is itself a culturally and historically specific approach to HBB that may not be appropriate or valid in all settings.

It is very important to parse out the difficulty inherent in the discussion thus far. By taking the line of thought outlined above, clinical psychiatry is placed in a position of being always-already an emic endeavor, insofar as it is itself a particular hermeneutic of certain kinds of human experience. When Fabrega, Kleinman, Kirmayer, and others investigate HBB across cultures, however, they assume an etic position, at least in that they believe there is something to investigate. For this reason, Fabrega has suggested that studying HBB always involves a form of ethnocentrism, and the tension inherent in this kind of inquiry may be irresolvable. In order to proceed, it will have to suffice merely to point out that, for cultural psychiatry, a strong cultural-relativist position is as untenable as a strong realist one. Between these two is one that maintains the ontological reality of psychiatric conditions, however construed, while upholding a weak cultural-relativist stance with regard to how they are to be known (epistemology). It is from this position that researchers are able to inquire into how it can be said that culture shapes psychiatric disorders.

### 1.3.3 The Role of Culture

Before moving further into the discussion of culture giving rise to psychiatric disorders, it is necessary to make an important distinction between the kinds of roles that culture is said to have in experience. “Giving rise to” implies an influence other than efficient causation, so it should be pointed out that such causation is not addressed here. Those discussions are normally had in terms of the “pathogenic”. For instance, one could argue that the brutality of Spartan culture was pathogenic if it was, in fact, a causal force in producing HBB among members of that society we might characterize as psychiatric. In a similar way, one could argue that certain cultural rigidities in parts of contemporary Japan are pathogenic in that they may be causes of conditions like *hikikomori*. For the purposes of this discussion, I set aside the pathogenic notion in order to discuss the “pathoplastic”, shaping role of culture.

The collaboration between anthropology and psychiatry reached a stage in the early 1970s
that facilitated the rise of cultural psychiatry as a discipline. The International Pilot Study of Schizophrenia (IPSS), which began in 1966, was the first large scale, longitudinal attempt at a cross-cultural study of schizophrenia, and it serves as a good example for clarifying the concept of “pathoplasticity”. At that time, psychiatrists understood schizophrenia to be an organic disorder of the brain/nervous system; however, the symptoms and outcome of the disorder were understood to be under the shaping influence of the respective cultural background of the patients. In other words, whatever the supraordinate pathology was, it was plastic (moldable or able to be shaped) as per the cultural context of the disorder.

In 1986 Kleinman pointed out that this pathoplastic paradigm had already become a psychiatric orthodoxy, the classical example being the delusional symptoms of a paranoid patient. In the USA, one might fear CIA mind-control, whereas in the USSR the fear might be of the KGB. While this example alone serves as one explanation of how culture shapes psychiatric disorder, it is not the most remarkable because it relies too heavily on a realist disease ontology that appears to pay mere lip service to a relativist symptomatology. The deficiency of such an approach becomes clear when considering the categories listed in the DSM-5 “Glossary of Cultural Concepts of Disease”. With only this notion of pathoplasticity, *Ataque de Nervios* would be seen as the cultural manifestation of the disease entity known under the DSM as “Panic Disorder”, *Susto* would actually be “PTSD”, *Nervios* actually “Anxiety Disorder”, *Shenjing Shuairuo* actually “Depression”, *Taijin Kyofusho* actually “Social Phobia”, and *Dhat* actually “Hypochondria”. This approach to pathoplasticity is precisely what psychiatrists like Fabrega try to avoid, although often unsuccessfully. When attempting to understand the role of culture in psychiatric conditions, a more sophisticated conceptualization is necessary.

1.3.4 Pathoplastic or Plastopathic Idioms of Distress

The term “idiom of distress” has been in use among cross-cultural researchers for nearly forty years, and it has been the subject of special issue publications within cultural psychiatry.

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41 These conditions are all explained in detail in the Glossary of DSM-5, and their explanation is not pertinent to the point being made here.

42 Plastopathic is my neologism. I am trying to indicate that the pathology itself varies in its ontological status; it is not merely that the manifestation varies.
As a research paradigm it has grown substantially over the years, and has been incorporated into the language of DSM-5. Anthropologist Mark Nichter popularized the term with his research in south Indian communities in the late 1970s, using the term to describe the socioculturally resonant means by which local persons manifested distress. He documented how, in one particular Indian cultural group, when women experienced severe family pressure or other difficult life circumstances, they engaged in behaviors that meaningfully indicated a distressed state to members of their community. In that particular case, the behaviors included food refusal or excessive fasting, expressions of fear of being poisoned, and disruption of normal commensality.

Though the details of those studies are not important here, Nichter’s research suggests that there are very particular forms of behavior that serve as socially and culturally specific ways of conveying affliction. This original conceptualization of idiom has undergone some change that should be addressed at this point, but it is important later to return to the notion of action and behavior as idiom.

Within the idiom of distress research agenda that developed in the years following Nichter’s work, there arose a very specific use of the term that came into wide employ. Numerous debates in the literature took place regarding what was called a “bias in illness cognition” on behalf of those undergoing some kind of distress or situation of suffering. Specifically, researchers developed the practice of eliciting the patients’ “explanatory models” of illness, and these models offered information as to the ways in which patients conceptualized their experience. The term “bias” is not intended to be pejorative in any sense; rather, it is meant to indicate that patients’ explanations of their experiences tend toward particular directions. For example, the most widely discussed issue in the literature pertains to the tendency to discuss illness experiences either using

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46 I will use the term “patient” here although other terms could suffice (i.e., participant, client, etc.).

47 The literature on “explanatory models” generally frames this issue in terms of a categorical distinction between “illness” and “disease”. For example, in *Rethinking Psychiatry* (1988, 7) Kleinman writes, “illness refers to the patient’s perception, experience, while disease refers to the way practitioners recast illness in terms of their theoretical models of pathology”. This division seems pragmatically sound for some purposes, despite the fact that the choice of the terms does harm to the etymology behind them. For example, “disease” really should not be lost in its meaning as an experience of “dis- ease”. The deficiency of relying on this dichotomy arises in Chapter 4.
psychological descriptors or bodily descriptors. Of course, this is especially important when no physical/physiological ailment can be identified. In such cases, the point is that a somatic bias in illness cognition would be evident when a person expresses distress by talking about physical symptoms such as body aches, feeling tired, headaches, and others bodily feelings. A psychological bias in illness cognition leads the person to express their distress by talking about psychological symptoms like feeling down, sad, blue, or similar psychological feelings. Cultural psychiatrists suggest that both ways of talking, in addition to evincing a bias in illness cognition, are idiomatic ways of expressing states of distress. This recognition of varieties of illness cognition seems to be an effort at self-reflection by those in the field of cultural psychiatry, recognizing the ethnocentric tension in claiming that one form of illness cognition is more correct or natural. The obvious caveat to the notion of biased illness cognition (and description), however, is that patients are actually undergoing the experiences that they explain themselves to have (i.e., body pains or emotional pain). This orientation to idioms gave rise to a debate in the cultural psychiatric literature as to whether patients from non-Western countries tended to express their distress in somatic idioms. Subsequently, decades of work by researchers in the field led to the canonization of “idioms of distress” in DSM-5 as having to do predominantly with language. It defines the concept as follows:

Cultural idiom of distress is a linguistic term, phrase, or way of talking about suffering among individuals of a cultural group (e.g., similar ethnicity and religion) referring to shared concepts of pathology and ways of expressing, communicating, or naming essential features of distress (e.g., kufungisisa). An idiom of distress need not be associated with specific symptoms, syndromes, or perceived causes. It may be used to convey a wide range of discomfort, including everyday experiences, subclinical conditions, or suffering due to social circumstances rather than mental disorders. For example, most cultures have common bodily idioms of distress used to express a wide range of suffering and concerns.

It should be obvious just from this description that the current DSM definition has changed significantly from the one offered by Nichter in his early research. For the DSM, idiom has been confined to its origins in linguistics in that its use is meant to reference particular ways of speaking about illness experience. While this is an important aspect of cultural influence on experiences

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48 Somatization is addressed in detail in Chapter 4, along with critiques of the concept.
deemed psychiatric, it misses the metaphorical sense in which idiom functions by analogy. For example, although a south Indian participant in Nichter’s research could describe her food refusal as a loss of appetite, others might engage in fasting without describing the undertaking as loss. Certainly, disrupting commensality need not be linguistic at all, and this non-linguistic sense of idiom deserves more discussion.

In order to turn to the non-linguistic sense of the term idiom, it is helpful to recall what idioms accomplish linguistically. Idioms, through cultural imputation, convey a meaning different from the literal meaning of a group of words used separately or together. In any given language, there are a myriad of idioms in use; English alone has thousands. For the purpose of example, we can consider just two: “doesn’t cut the mustard” and “let the cat out of the bag”. It is obvious that the respective meanings, understood by their correct use, have nothing to do with the literal meanings of the phrases. The appropriation of the term “idiom” by ACP is based on the fact that idioms express their signification by means other than the literal.

When not used in a linguistic sense, the concept of idiom must be understood to function analogically. One need think only of the reference to idiomatic expression in various genres of music for this to be clear. For instance, it is not uncommon to hear musicians talk about “jazz idiom” when discussing the compositions of George Gershwin. This analogical use of idiom has provided researchers a useful means of conceptualizing certain types of experience. But what does it mean for an action, behavior, or experience to be idiomatic in the sense Nichter means it?

Having seen that idioms are meant as symbolic indicators of what should be inferred by others, we can reconsider non-verbal examples. As mentioned above, it may be that patients describe their experiences (e.g., tightness in the chest or shoulders) in ways that may be idiomatic indicators of other problems (e.g., severe strain from job loss). However, the actual experience of tightness itself is non-verbal. In a similar way, it is evident that the experience of fainting is non-verbal. In a context where there is no physical/physiological explanation for fainting spells, the fainting can be termed idiomatic insofar as it is not seen as the literal problem needing ultimate attention, but rather is a symbol or indicator of something of greater significance.

50 “George Gershwin: American Composer,” Encyclopedia Britannica, accessed October 24, 2018, https://www.britannica.com/biography/George-Gershwin. For example, consider the claim that, “the revolutionary work incorporated trademarks of the jazz idiom (blue notes, syncopated rhythms, onomatopoeic instrumental effects) into a symphonic context” in this biographical article.
Researchers have documented numerous examples of behaviors and actions that are believed to serve as idioms of distress in their respective cultural contexts. Nichter’s documentation of fasting in India has already been mentioned, and food refusal has been interpreted in numerous contexts around the world as being a culturally appropriate form of expressing distress (Sing Lee, Hong Kong and China; McLawhorn, Taiwan; Stark-Wroblewski, Japan; and others). DSM-IV included fainting spells as a cultural idiom in the southern USA, and the act or attempt of suicide has itself been described as having become a culturally understood idiom in certain locations (Kral, Arctic North; Zayas, Latinas in the USA). In addition to these behaviors, which continue to be studied, there are also examples of illness expression that have been studied historically.

For example, Ian Hacking has written about the very bizarre phenomenon of dissociative walking-fugue, which became a nosological category in nineteenth century France (Hacking 1998). Doctors encountered epidemic incidence rates of dissociative walking-fugue followed by a nearly complete cessation of the phenomenon within a matter of years. A great deal has also been written on the late nineteenth- and early twentieth-century histories of neurasthenia and hysteria as categories of experience with very specific symptoms. These categories of experience illustrate that types of behavior that appear to be idiomatic for severe distress can take on or lose their cultural meaningfulness historically.

1.3.5 Cultural Symptom Pool

In his work On the “Disappearance” of Hysteria: A study of the clinical deconstruction of a diagnosis, historian Mark Micale argued that the formal diagnosis of hysteria underwent “atomization” followed by a “reconstitution in many new places under a multitude of different

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names that has created the historical illusion of a disappearance of the disorder itself”.54 His archival work demonstrates that clinical categories become parsed and disseminated within newer nosographies, and his historical findings probably are easily applicable to other categories such as neurasthenia. However, something seems to be missing in such explanations. It is one thing to agree that a patriarchal system constructed the category of hysteria only to alter and have it subsumed under other categories later; but it is very different to suggest that such is the extent of the meaning and mechanism of hysteria’s “disappearance”. After all, the classical Charcot-style hysterical fit did seem literally to disappear shortly after Charcot’s death. And there are many other examples of visible, tangible symptoms that prevailed only temporarily in history. How could this happen?

The historian Edward Shorter has attempted to address this problem in several works on the historical phenomenon of psychosomatic illness.55 From the main title of his earlier work From Paralysis to Fatigue, the reader can see that Shorter intends to explain how the experience of paralysis as a defining feature of neurosis can shift toward fatigue as a defining feature, all within the span of a generation. He employs the metaphor of a “symptom pool”. For instance, the epidemic rise of neurasthenia in the late nineteenth and early twentieth centuries can be seen as the creation of a clinical category that contributed to a symptom pool out of which sufferers/patients could draw. The bodily experiences were taken on as distraught individuals somehow conformed to the culturally available symptoms found in the symptom pool.

Hysteria very likely worked in just this same way. The symptom pool model can explain how hysteria was both the creation of patriarchal doctors, and at the same time, an accurate description of the symptoms that predominantly affected disturbed women.56 Did women really manifest hysteria in such large numbers? Yes, they did. And they did so because they believed it to be an actual disease that afflicted them.57 In Charcot and Freud’s day, there was a clearly defined

56 Men are not completely excluded here, but that is a subject of other works. Most hysterics were women.
57 When you conceptualize hysteria this way, it is no longer necessary to try to find a way to discredit the overwhelming evidence that women were, in fact, presenting with such florid, visible manifestations in a way that men were not. At the same time, the medical establishment and patriarchy are not at all ignored or excused, as they were the main legitimizing and defining force that made the category a possibility of embodiment in the first place.
symptom pool that was socially recognized and attached to a sick role, and it created a culturally appropriate form through which distress and life disruption could be manifested. As the symptom pool changed and its legitimacy came into question, so did the experiences of those who had previously conformed to it. In this way, the idiom lost its meaningfulness as circumstances changed in the external world, which was the very source of its original legitimacy and meaning. So the analogy holds with language: some idioms are understood despite being anachronistic (“burn the midnight oil”), while others may lose their meaning (“drop a dime”) in a generation. Obviously, there are idioms that are unavailable for other reasons (“well-bottom frog”, 井底之蛙 for example). The point is that idiom depends on a geographical and historical community for whom the idiom is meaningful.

1.3.6 Conclusion

At this point I want to summarize by returning to the main question regarding culture shaping psychiatric disorders. Given the general definition of culture mentioned above, and the range of experiences that are of psychiatric interest, I have tried to explain that there exists a necessary relationship between how people experience suffering and how they conceptualize and understand themselves and the world.

Criticisms of psychiatry often reference Michel Foucault in order to argue that the power belonging to psychiatry constructs clinical entities and thereby medicalizes human experiences. A perhaps subtler side of Foucault, not often employed in the social sciences or humanities, raises questions about a different aspect of power: how do implicit powers of knowledge and representation serve as internalizing forces in the life-world of a subject so as to make possible the varieties of illness experience and local/cultural idioms of distress that the subject then manifests? This same form of power, often attributed to the psychiatric profession, is equally attributable to all aspects of culture, which provide meaning and norms of behavior. Culture serves as the force that makes fainting a meaningful symptom in the context of nineteenth century European understandings of human responses to stress, embarrassment, or shock. Culture and socialization are forces behind at least some of the experiences of Chinese complaints of weak nerves and Latino

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58 The “well-bottom frog” is unavailable for a number of reasons. First, if the reader/hearer encounters Chinese as an unfamiliar language, the literal words will not even be known. However, even if one knows the language, the idiom is veiled. Interestingly, if one is familiar with Japanese, the idiom is somewhat self-explanatory (井の中の蛙大海を知らず).
descriptions of “attack of nerves”. However, if the culture provides an alternative symptom pool to draw from, people will learn to draw from that as well.

Finally, the existence of idioms of distress that derive their meaning from cultural systems is indicative of the embodying power of culture in the experience of the psychiatric. The local idioms that arise through the medicalizing and categorizing influence of the discipline of psychiatry, that arise as a result of traditional medical beliefs and narratives, and that come from a host of other religious or philosophical views, all serve to shape human experience and understanding. The universal human experience of severe distress, demoralization, and behavioral breakdown must always occur within a cultural context; and it is culture that shapes and sanctions a meaningful outlet for such experiences. It should be kept in mind that the model of idioms of distress that I have framed here does not rely on patients “talk” about bodily symptoms. Rather, the available experience itself is the idiom, whether that be a subjective experience of dysthymia or a collection of aches and pains. Such are the indicators and consequences of human distress and difficulties in living.59

1.4 Method

Attempts to apply the theoretical considerations of the previous section to the subject of SJSR and to my basic questions may be approached from a few possible directions. Methodologically, the vast majority of published research on SJSR has been from the orientations of ACP. Almost invariably, the preferred methods used are qualitative and ethnographic in nature. These include modifications of the psychiatric clinical interview, observation in hospitals, and more traditional ethnographic interviewing approaches that employ in-depth interviews with a grounded theoretical approach, among others. These are most often employed in order to elicit from patients the meaning of their symptoms and experiences. Occasionally, quantitative methods are used in order to determine numerical data regarding epidemiological or clinical questions. Some of these matters are addressed in the later chapters, but they are worth mentioning here to point out that I do not use the methods predominant in the research on this topic. Rather, I use a

59 I have tried to stay distant from the notion that a collection of aches and pains serves as an idiom for dysthymia, for example. In fact, I reject the idea that this need be the case. Such notions will arise in later chapters. Regarding “difficulties in living”, I mean this phrase in the sense employed in the interpersonal psychoanalysis of Harry Stack Sullivan.
multidisciplinary approach that might be termed “textual studies”, “literary studies”, “historical ethnography”, or some other amorphous description pointing to the source of information for my study. I take as my source of data a variety of print texts that span the turn of the twentieth century to just a few months ago, all of which are written in English, Chinese, or Japanese. Additionally, there will be instances where I make reference to a photographic or other visual text that was produced with these same three language populations as its target audience. I address these sources below, but it is worth first taking some step toward describing my motivation for a textual approach, rather than the predominant methodology, when studying this subject matter.

Returning momentarily to Ethan Watters, we might consider an example of textual studies that informed his chapter on depression in Japan. In that chapter, he relied heavily on the work of Junko Kitanaka, whose doctoral dissertation was published under the title, *Depression in Japan: Psychiatric Cures for a Society in Distress*. Given a variety of academic concerns regarding the global medicalization that appears to happen through the influence of American biomedicine and psychiatry, Kitanaka set out to examine how, “at the turn of the twenty-first century, depression has suddenly become a ‘national disease’ in Japan”. The second half of her book is largely ethnographic in nature, and through careful analysis, she was able both to address what depression means to contemporary patients as well as to contribute to theorizing about what kind of cultural work the category of depression was doing in Japanese society. It is noteworthy that she seems to have rightly recognized that the ethnographic work ought not be carried out in isolation from some more fundamental inquiry regarding the various meanings of the category itself in society. That is to say, she wanted to know when *Utsubyou* came into popular use in Japanese society, what the sources of popular understanding were, the manner in which it was described, and other such issues.

61 For instance, if she intended to ask the ethnographic question, “What are patients referring to when they make reference to their personal experience of *Utsubyou*?” then the second half of her work may have sufficed. However, the question, “What are we referring to when we make reference to *Utsubyou*?” requires a form of inquiry akin to an “archaeology”. In other words, she hoped to understand what made the meaning of and patient reference to the category possible in the first place. Analogously, a number of researchers have been studying SJSR from the position


61 *Utsubyou* (うつ病 or 鬱病) is the Japanese term for “depression”.

of patients’ explanatory models as assessed by the former ethnographic question, without ever having any firm footing in the latter archaeological question.

A similar approach from the USA might be helpful here. I am deeply indebted to the archaeological efforts of Ian Hacking, who has attempted to come to grips with the same fundamental body of knowledge necessary to give rise to the explosion of multiple-personality disorder (MPD) diagnoses in North America.\(^6\) While MPD was exceedingly rare (and those few patients normally had one or two “alter” personalities) in the middle of the twentieth century, in the 1980s there appeared to be an explosion of people diagnosed with the disorder, often having more than a dozen personalities. Furthermore, there were numerous books and movies released about the topic in that decade. Hacking wanted to know what the pre-conditions were for what appeared to be the rise of a new phenomenon. Ethnography of patients and physicians would probably not have served well, and so he turned to historical texts, professional texts, and popular works of fiction and autobiography, which he argued served in some ways to lay the social groundwork for an epidemic rise of MPD experiences. I believe that relying on ethnographic methods to elicit patients’ explanatory models has tended toward an overestimation of what that approach can tell us about patient experiences; furthermore, I contend, throughout this project as a whole, that ACP research has ended up giving us a synchronic analysis that fails to consider certain possibilities regarding how human categories diachronically affect those who populate them.

I view the present project as residing in the same family of inquiry as both Kitanaka and Hacking. In the social sciences, humanities, and philosophy, textual analysis is a research method with a long and rigorous history. After all, “most of the recoverable data about human thought and human behavior are texts of one kind or another”.\(^6\) Following the sociological tradition in textual studies, I view texts as a “window into human experience”,\(^6\) but I do not engage in the study of my sources using formalized coding or other means of objectification of data. Instead, I examine literary, professional, and lay texts of varying types with the aim of understanding the social, cultural, historic, lay, and professional constructions of SJSR, and with a consideration of how

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\(^6\) Ibid.
those constructions have been contested and challenged.

1.5 Approaches to Sources

In the pages that follow, needs vary depending on the aim of the chapter. The analysis of professional, academic literature in Chapters 4 through 5 requires very different material from either Chapters 2 or 3. For this reason, in the next few sections I provide an account of how I chose source materials for the respective chapters. In a work of this kind, it is not usually necessary to explain the means of editing relevant source materials, and this is especially so in Chapter 2, as it offers an analysis of the Western discourse of nerves using materials dating back to the seventeenth century. However, if perchance the reader desires to know how I came across source materials, this information is available in the next few pages. Additionally, bibliographic information is all contained in the footnotes of each chapter.

1.5.1 Sources for Chapter 2

Chapter 2 includes a literary and historical approach to nervous discourse in the West that relies on a large number of original writings, both fiction and non-fiction, dating from the seventeenth century to the twentieth. Also included is reference to relevant secondary literature on neurasthenia in the West. In selecting primary source materials, I initially relied on my own recall of reference to “nerves” in English-language fiction. This led to document and digital searches for references to “nerves”, “nervous disease”, and “neurasthenia” across a variety of writings. The non-fiction materials making up Chapter 2 are the result of archival and database searches used in traditional historical research. These are primarily professional, medical texts written in some instances for a lay audience. In most cases, they are monographs that appear to have been intended by their authors to serve as medical textbooks. It is not always clear when a large work is intended as a reference work for a general audience or is meant to serve as a specialized volume for the use of fellow physicians. In any case, the number of works cited in the chapter makes such distinctions unnecessary.

1.5.2 Sources for Chapter 3

In an effort to step away from the synchronic approaches that dominate the research on SJSR, I turn in Chapter 3 to a broad variety of materials dating from the end of the nineteenth century to the founding of the People’s Republic of China. Archival sources from the Japanese
Diet Library and secondary literature help situate the early uses of the kanji for SJSR and the understandings of the disorder in Japan. With respect to China, however, I take two approaches.

First, part of my argument about a modernizing China comes from my own thinking about Lu Xun and other figures drawn from a “canon” of modern Chinese literature. Choice of these sources is entirely dependent on the argument that I wish to make, and they include figures like Yu Dafu, Pan Guangdan, Mu Shiying, Arthur Smith, and others. My overall aim is to get at everyday understandings of SJSR as it became popular, to get at what became common knowledge and taken for granted, and I draw on the sources that help make my argument.

Second, I describe the increasingly available common knowledge of SJSR that served as the context for those writers I employ to make my argument. At that time in China, there were myriad publications that resulted from the new presses of the Republican Era. A large and growing network of periodicals, newspapers, gazettes, journals, primers, and other sources of information were in regular and available circulation throughout the period. To capture the kind of domestication that SJSR underwent, I have read numerous such materials that are now available in a variety of archives, both digital and physical. I mostly draw on the newspaper Shen Bao as it provides an interesting glimpse into what information on SJSR was available to the reading public for decades prior to the founding of the PRC. There were daily advertisements and descriptions printed in its pages and some are selected here for consideration.

1.5.3 Sources for Chapters 4 and 5

Chapters 4 and 5 are likely to be the only chapters about which some readers would prefer to know the method for source selection. In Chapter 4, my sources are entirely limited to academic writings on SJSR as it has been studied and framed by anthropologists and psychiatrists from the mid-1970s to 1989. These materials are primarily written by scholars in North America, but there are also a number from East Asian countries who are writing for their colleagues in international and Chinese-language journals. That chapter is not merely a literature review, although it is also that; it is a critical engagement with the predominant interpretation of the meaning of SJSR that has shaped how the category is understood by Western psychiatry on the global scene.

An extensive professional literature on SJSR has developed in North America since the time of Arthur Kleinman’s original research in the late 1970s. In assessing the theoretical model that grew out of that research, I have examined several of the monographs (five volumes) and
edited works (three volumes) that Kleinman has produced. Additionally, I have selected a sample of academic papers that deal specifically with SJSR in China, Hong Kong, Japan, and Taiwan.

There are a variety of ways to go about establishing a group of adequate source materials on SJSR from the published literature, but the papers are voluminous. For this reason, I have made a careful selection based on a systematic search of the PubMed databases within the timeframe covering 1970–2017. I chose this start date primarily because it was not until the 1970s that researchers had access to China after Richard Nixon’s visit in 1972, and it was not until the end of that decade that Kleinman began his research.

With respect to engagement of ACP by Chinese psychiatry, I have sought out responses and reactions to American scholarship, much of which has been produced in Chinese without any representation in English-language psychiatric literature. For instance, there are numerous Chinese language responses to important ACP texts that American psychiatrists have never seen in translation; consequently, many have not had the privilege of hearing Chinese responses to Western interpretations of psychiatric nosology in China. Additionally, I have engaged original research by Chinese psychiatrists who have been involved in the debate on SJSR that arose in the 1980s. I attempt to bring these two monologues into dialogue.

1.5.4 Sources for Chapter 6

Chapter 6 serves as the conclusion of the study. It does, however, briefly address the state of the theorizing about SJSR from 2010 to the present. Some of the material in this chapter is accumulated as discussed above. Additionally, I incorporate some English and Japanese language sources regarding the diagnosis of autonomic nervous system disorder in Japan, which I find interesting when viewed comparatively with SJSR. I also draw on some recent research in the field of cultural neuroscience in order to offer an introductory explanation for how people can draw from available categories in a way that is transformed into embodied experience.

1.6 The Need for This Project

In Section 1 of this chapter, Questions and Their Contexts, I mention in passing that the English language research on SJSR is plenteous but not always helpful. Many of the references to SJSR in ACP seem to repeat the same group of sources and citations without any critical reflection concerning possible alternative ways of thinking. Much of the literature from that perspective and
methodological orientation is addressed in Chapters 4 and 5. In this final section of the chapter, I refer the reader to some historical research on SJSR that is helpful in gaining an understanding of its meanings, with an aim toward demonstrating how the present project takes a different approach and makes its own contribution to the existing literature.

Wen-ji Wang has produced a few very informative pieces regarding the contested models of SJSR among Republican-Era professionals from disparate theoretical orientations in psychiatry and psychology. In *Tropical Neurasthenia or Oriental Nerves*, he addresses the topic of nervous illness and neurasthenia as an affliction of Westerners living in China. He describes how it is variously attributed to climate, cultural differences, repressed sexual desire, incessant status of being a gazed-upon foreigner, and constant exposure to the degraded sociological condition of China, as competing claims about its meaning were navigated by medical authorities.  

Continuing his analysis of competing models among practitioners, Wang has recently outlined a role for neurasthenia in the development of the “psy disciplines” of Republican China. He begins with initial German and Japanese notions of the disorder as they exist in professional monographs and journal articles, which primarily view the epidemic as: “an adverse effect of modern lifestyle, which would destroy an individual’s physical and mental health and sap the nation’s vigor”. From those origins, he suggests that, by the 1940s, there was a trajectory of changing conceptualizations among professionals as SJSR was gradually understood to be the result of psychical conflict rather than an organic disease of the nervous system. Part of this he sees as an attempt to stake out territory and professional boundaries for the disease; rather than being a disease treatable by any physician, SJSR needed a clinician from the “psy disciplines”. The psy-clinicians at that time were competing with popular discourses of SJSR and the huge market of patent medicines, such as Ailuo brain tonic. Psychoanalytic/psychodynamic schools of thought, which were growing in influence, increasingly viewed the disorder as a series of neurotic symptoms that served as an escape from distressing social difficulties, a view growing in

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prominence in the USA as well.\textsuperscript{69} However, Wang recognizes that there was also a vast “popular psychological discourse on neurasthenia in the late Republican Era” that was available to the everyday consumer, further complicating the rich history of the disorder.\textsuperscript{70} The same types of eclectic and varied approaches are also present in his analysis of Gu Jiegang’s experience with SJSR.\textsuperscript{71}

Though already mentioned, Hugh Shapiro should be applauded for producing insightful discussions of SJSR across a number of publications. His efforts at describing the assimilation of nerves in China are rigorous and thoughtful analyses of historical materials. The subject of his previously mentioned paper is taken up further in “How Different are Western and Chinese Medicine? The Case of Nerves”, which he prepares for a volume on the history of science across cultures.\textsuperscript{72} In short, his argument is that the term \textit{shenjing} took root in the Chinese lexicon as a result, not of sophisticated efforts of anatomists and translators, but rather as a result of Japanese discourses of nervous weakness; in other words, the usefulness of the concept of “nerve” for physiological understanding was secondary to the ability to refer to nervous pathology in a way that related to “age old ideas about depletion”.\textsuperscript{73}

One specific example of those old ideas of depletion can be seen in his work on spermatorrhea, or the loss of seminal fluid.\textsuperscript{74} Using literary, medical, and commercial materials from the Qing to the Republican Era, he offers a fascinating discussion regarding the concept of vital essence and the variety of ways that it can be depleted through the wanton or unintentional loss of seminal fluid. Thereafter he devotes one page to the “discourse of nerves”, and suggests that the spermatorrhea in Chinese medicine since late antiquity was reformulated as “a deep-seated

\textsuperscript{69} It should be pointed out that within the psychoanalytic thinking of Freud, neurasthenia was seen as an actual neurosis; that is, an organic disease resulting from disordered use of the sexual function, which then had deleterious consequences for the nervous system, and is addressed in Chapter 3. Later psychodynamic thinkers viewed neurasthenia as a “psychoneurosis” that results from conflicts in emotional life. This latter view is part of the influence for the model of SJSR discussed in Chapter 4.

\textsuperscript{70} Wu and Wang, “Making and Mapping Psy Sciences in East and Southeast Asia,” 153.


\textsuperscript{73} Ibid., 366.

\textsuperscript{74} Hugh Shapiro, “The Puzzle of Spermatorrhea in Republican China,” Positions 6, no. 3 (1998): 551. The Chinese term for spermatorrhea is \textit{Yijing} (遺精).
constitutional disorder arising from weakened nerves [and so] the nervous system became the new substrate for an age-old depletion disorder”.75 He concludes with the question as to whether SJSR in China represents a new disease or a different way of referring to the older disorder of depletion, yi jing. He finds this question central to “understanding the modern transformation of the Chinese body”.76

For the sake of being thorough, I point the reader to one more discussion of SJSR that Shapiro offers in an edited, illustrated history of Chinese medicine.77 As he seems to have the most thorough and rigorous grasp of the issues involved in SJSR’s rise and persistence in China, it is worth pointing out his struggle in conceptualizing the disorder. In this short piece, he calls it “a modern disease but also a disease of modern people”, and concludes that “neurasthenia in China might have less to do with the modernity that gave birth to this particular category of distress and more to do with underlying intuitions regarding how the body works”.78 He also states that, today, in “China’s major cities and leading medical centers, the term shenjing shuairuo has entirely dropped out of medical discourse, and educated youth in such places as Shanghai and Beijing find the term ‘neurasthenia’ alien and puzzling . . . [Y]et the idea lingers on, appearing in self-help manuals and often tied to insomnia. Some clinicians still publish articles on the condition”.79

In the first few pages of this chapter above, I have already demonstrated that SJSR has not dropped out of medical discourse, and it obviously cannot both be dropped from discourse and have clinicians publishing on it. This kind of tension as well as the tension in trying to understand the category in relation to “modernity” both point to the difficulties in knowing what we are

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75 Ibid., 581.
76 Ibid., 581. This is a rather cliché sounding phrase that is very common in academic writing from the orientation of both history and anthropology. Obviously, there is no clear or precise meaning that could possibly be inferred from “transformation of the Chinese body”, but such phrases are often used with the reader left to make their own assumptions regarding whether it is intended to mean some type of conceptual transformation of the meaning of the body, a change in bodily experience, or something else. A change in bodily experience may very well be intended here, but this raises serious questions that are never addressed by the haphazard use of such phrases. How does an idea or concept change a bodily experience? Are not all experiences mediated by physicality? How would a bodily experience be changed then? Through what mechanism? Without asking such questions and attempting to answer them, modern academics engage in a strange mystical dualism that is filled with conceptual gaps as to what could possibly be meant by such phrases.
78 Ibid., 228.
79 Ibid., emphasis mine.
referring to by the term. It also demonstrates the manner in which Western discourse on SJSR has increasingly dismissed the diagnosis as obsolete or irrelevant.

In a somewhat similar fashion to Shapiro’s look at spermatorrhea, Dikotter examines a large number of Republican-Era periodicals in his study of *Sex, Culture and Modernity in China.*80 Within this work, neurasthenia occurs only a handful of times, in each instance relating neurasthenia to some aspect of the sexual function. For instance, spinsters who never absorbed invigorating male secretions might suffer neurasthenia and anemia in older age.81 Excessive intercourse could lead to sexual neurasthenia.82 Excessive physical labor/activity during pregnancy could drain the finite resources of the nervous system.83 Excessive sexual promiscuity and masturbation could lead to nervous exhaustion.84 In each of these instances, the view of SJSR that he documents, as described by his sources, is nearly identical to some of those views attributed to George Miller Beard, who first popularized the term neurasthenia in the late 1800s. In any case, Dikotter does not have a great deal to say regarding SJSR in that book, but he does make the case for a modernizing discourse that became available in the form of printed texts and shaped how readers viewed the world and their lives. Ultimately, he argues that modernizing discourses “were not generated by an integrated scientific community under state control, as in Germany during the same period, but by a loose association of more or less independent intellectuals from a variety of disciplines”85 that were ubiquitous in the everyday life of literate people, owing to the explosion of printing houses and commercial presses vying for public attention. He describes their effect as one wherein “new structures of knowledge were created, maintained and perpetuated through texts, which can be interpreted as semiotic encounters through which meanings that constitute social reality are exchanged . . . [T]exts both reflect and act upon the environment”.86

Compared to those prior approaches to SJSR, this current project is rather different. Consider what has been presented thus far. The work of Wang helps us see how professionals have conceptualized the disorder over time, Shapiro helps us understand the intellectual history that

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81 Ibid., 47.
82 Ibid., 56.
83 Ibid., 99.
84 Ibid., 162–164, 169, 182.
85 Ibid., 5.
86 Ibid., 7.
may have made the concept palatable, Dikotter has touched the surface of what Republican-Era citizens may have begun to believe about SJSR, and ACP writings take a synchronic look at the explanatory models and meanings of contemporary patients as they experience their illness.\textsuperscript{87} If an example of any one of these approaches is looked at carefully, it will be found that, in addition to the main aim of the research, some reference must be made to the other approaches for the purposes of background and clarification. For example, authors almost invariably offer a very brief description (sometimes one paragraph but at most a couple of pages) of the Western origins of SJSR, after which they often make briefer and uncritical reference to the interpretations of SJSR offered by ACP.\textsuperscript{88} Afterwards, the bulk of the writing is dedicated to the sources and aim of the respective writer.

My goal in the present project is to answer my primary questions by addressing what can be known from all of these approaches; that is to say, within one project, address three areas of related concern. This is an effort to survey the whole epistemology of SJSR. Therefore, I dedicate space to the following 1) a detailed explication of neurasthenia’s geographical and historical origins; 2) a detailed consideration of what SJSR likely means to the average person in the twentieth-century;\textsuperscript{89} and 3) a detailed examination of the ACP approach since its inception, with the aim of demonstrating how it has served to re-frame and re-define SJSR in terms of the DSM.

In order to make clear to the reader that the chapters to follow are not engaged in some outdated straw man argument, let me briefly give some examples of how the materials addressed in chapters 4 and 5 have influenced the field of cultural psychiatry and its engagement with patients. Some readers of this manuscript might be tempted to suggest that the present work does not demonstrate an understanding of anthropology. In fact, I am not interested in the current fads in anthropological theory, driven by the winds of academic fashion. The fact that I spend large sections of this manuscript addressing anthropologists’ writings from the 1970s, 80s, and 90s ought not to misguide the reader into the false notion that I am dealing with outdated material, though

\textsuperscript{87} There are other researchers who write about SJSR that will arise throughout this work. I mention these four for the purpose of illustration only, and they are not intended to be exhaustive. However, the overwhelming majority of writings on neurasthenia take one of these four orientations.

\textsuperscript{88} Wang is an exception in that he seems critical of the somatization model.

\textsuperscript{89} In this second endeavor, Chapter 3, my approach is closest to Dikotter, as I believe texts constitute social reality. The best way to get at what people believe about SJSR is, of course, to ask them, hence the voluminous work of ACP. However, the understandings, meanings, and experiences elicited by ACP only capture the meaning of a particular moment.
fads they once were (and continue to be for many, as indicated by the material listed in the next pages and in subsequent chapters). When picking up a book subtitled *What Anthropology and Psychiatry Tell Us about China Today*, there can be no doubt that the text is involved in making a claim about the role of anthropology. The inadequacy of the claims in that text, specifically with respect to SJSR, are dealt with clearly in the concluding chapter below. That book was published in 2011 and can hardly be considered an “early work” of its individual authors and editor. The point more clearly to be made is that the authors of that text have had a large and lasting impact on cultural psychiatry, and the “seminal” claims and interpretations of Chinese experience with SJSR that arose from the “New Cross-Cultural Psychiatry” are continuing to cloud the hermeneutic frame through which contemporary writers view the East Asian experience.

For example, in 2018 Cambridge University Press published the *Textbook of Cultural Psychiatry*, purported to be “the best response currently available in the psychiatric literature” to the complex array of unmet needs in regard to a “culturally informed approach to psychiatric training, clinical practice and research”. As an authoritative text on matters pertaining to the intersection of culture, social science, and psychiatric knowledge, the volume pulls together numerous chapters authored by various scholars in the field. With regard to SJSR, a common theme can easily be found.

In the fourth chapter, titled “Psychology and Cultural Psychiatry,” we read that, “Kleinman’s suggestion that depression can also vary across cultures and across different historical epochs is quite consistent with a biological view of depression . . . Kleinman has suggested that while depression and neurasthenia are different illness experiences, they are both products of the same underlying disease process—depression. In other words, neurasthenia is the Chinese version of ‘Western’ depression . . . Kleinman believes that the ultimate cause of depression and neurasthenia is the same . . . In summary then, Kleinman (1980, 1982) suggested that depression and neurasthenia have similar socio-political origins, which produce a similar biological disease

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91 For discussion of the “New Cross-Cultural Psychiatry,” see Chapter 4, Section 1 below.
process, which expresses itself differently in North America and China because the different cultural conditions favor different forms of expression”.

In the eleventh chapter, titled “Psychopathology and the Role of Culture,” we read that, “Kleinman (1982) conducted a clinical study of patients diagnosed by Chinese clinicians as having neurasthenia, and observed that 87 percent of the patients he examined could be ‘re-diagnosed’ as having a depressive disorder according to Western criteria. However, many prominent Chinese psychiatrists insisted that neurasthenia was a recognized psychiatric disorder distinct from depressive disorders . . . Thus parallel diagnoses need to be looked at closely in research and clinical criteria”.

In the eighteenth chapter, titled “Neurotic Disorders: Anxiety and Fear Related, Dissociative and Bodily Distress Disorders,” we read that, “Shenjing Shuairuo, known as neurasthenia in the West, is a condition highly prevalent among the Chinese . . . There is an ongoing debate regarding whether or not this is a Chinese label for depressive disorders”. The authors continue in a later section by claiming that, “Neurasthenia, also known as chronic fatigue syndrome (CFS), is a condition of uncertain cause commonly ascribed to the effect of stresses of modern life on the human nervous system”. After a brief discussion of Japan they go on to mention that, “In China, neurasthenia or shenjing shuairou meaning weakness of nerves is reported by intellectual individuals with probable socio-political factors underlying the cause”.

In chapter twenty, titled “Affective Disorders Coloured by Culture: Why the Pigment of Depression is More Than Skin Deep,” we read that, “Major depressive episodes (MDEs) as defined by DSM are fundamentally a Western Construct . . . Kleinman in the 1980s suggested that the diagnosis of neurasthenia was highly prevalent in China (shenjing shuairuo) and manifested there by way of bodily symptoms, including weakness, fatigue, tiredness, headaches, dizziness and

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96 Ibid., 207.
97 Ibid., 213. The typo “shuairou” is in the original and should be “shuairuo”.
gastrointestinal afflictions (Kleinman 1982). His seminal work emphasizes that depression can manifest differently depending on the cultural context in which it occurs”.98

A familiarity with the cultural psychiatric literature should make clear that I have not misunderstood the impact of the intersection of anthropology and psychiatry when it comes to SJSR, especially as I critique it in chapters 4 and 5 below. The citations listed in the preceding paragraphs draw directly from and rely on the work of Kleinman. The impact of that literature on psychiatric theorizing and practice is clearly being referenced in the World Psychiatric Association’s 2002 consensus statement on neurasthenia where we read, “Contrary to some current beliefs and recent reports, Neurasthenia syndrome is a common problem occurring in all parts of the world. The syndrome has significant negative consequences for individuals and to society and is therefore a public health problem of major importance requiring improved recognition, understanding, research and education”.99 Nevertheless, the neurasthenia-depression controversy is alive and well, and current attempts at understanding that controversy continue to generate interesting philosophical discussion.100

SJSR has become deeply ingrained in the lives and thinking of Chinese-speaking people over the past 130 years. It is my desire that the pages that follow help to broaden our view of SJSR as a category of human experience. I suggest that since its first encounter with SJSR, Western psychiatry has engaged in a rather hegemonic effort at reducing the concept to a size and shape that fits the DSM, beginning with DSM-3 and continuing to the present edition. I hope this project makes possible the consideration that SJSR may still be relevant for some forms of human suffering, perhaps even outside of Chinese experience. I also offer a warning for psychiatry regarding what is at stake in the creation of nosologies and their conceptual categories, as there are (as yet) poorly understood ways in which beliefs about experience can have real and physical/embodied consequences for the persons holding those beliefs. It is too early to determine to what extent Western psychiatry has or will succeed in convincing the Chinese that SJSR is an

obsolete or invalid category; we also do not know what future resistance to Western impositions of “knowledge” will arise with China’s growing influence in the world. Perhaps one day the DSM will re-incorporate an SJSR-like category. With these ideas and goals in mind, I now turn to the historical origins of neurasthenia.
Chapter 2: Western Origins of Neurasthenia

“Mr. Bennet . . . you take delight in vexing me. You have no compassion on my poor nerves”.

“You mistake me, my dear. I have a high respect for your nerves. They are my old friends. I have heard you mention them with consideration these twenty years at least”.

“Ah! You do not know what I suffer”.

Jane Austen, Pride and Prejudice (1813), Chapter 1, p. 3. (Mr. and Mrs. Bennet)

In the 2005 film adaptation of Jane Austen’s Pride and Prejudice, Brenda Blethyn gives a wonderful performance of the extremely nervous Mrs. Bennet, who is the mother of the main protagonist in the novel. Upon hearing that her young Lydia has eloped with Mr. Wickham, Mrs. Bennet laments the suffering that the situation causes her: “Lydia must know what this is doing to my nerves, such convulsions, such spasms over my body!” The brief monologue that continues in this scene is not depicted exactly the same way in the novel, but we read in Chapter 46 that, as a result of the news, Mrs. Bennet has become so ill that she keeps to her room without any ability to exert herself whatsoever (p. 280). Her character in the story is representative of a type of person not unknown to readers of the day, and her complaint that others are not sensitive enough to her “poor nerves” (p. 3, 4, 118) is one that is repeated both within the novel and across other works as well.

For example, in Austen’s 1811 novel, Sense and Sensibility, Marianne’s “nerves could not then bear any sudden noise” (p. 162), “she has had a nervous complaint on her for several weeks” (p. 183), has “nervous irritability” (p. 143), “she is very nervous” (p. 191), and has “nervous headaches” (p. 176). Almost one hundred years earlier, Daniel Defoe’s Robinson Crusoe (originally published in 1719) makes reference to illness and fatigue that lead the protagonist to declare, “I had frequent convulsions in my nerves and limbs for some time” (p. 87). Sir Walter Scott made reference to nerves in Ivanhoe (1820), The Betrothed (1825), and in The Talisman (1825), where we read that indulgence and debauchery in use of Hakim’s elixir will “rend the nerves”, a result of the misuse of all those things “Allah hath sent on earth for a blessing” (p. 150). Dickens used the adjectival form several times in Oliver Twist (1838–1839), and referred to “nervous” persons sixteen times in Nicholas Nickleby (1838–1839), both works being published serially over the course of approximately a year. The notion was also popular outside of England, as can be seen by Washington Irving’s references to “nervous fits” (p. 69) and “nervous gentleman”
(p. 17, 23) among other such descriptors that occur at least seven times throughout his *Tales of a Traveler* (1824). Similarly, nervous derangement, nervous affection, and the like occur thirteen times in Harriet Beecher Stowe’s *Uncle Tom’s Cabin*.101

The list could, and does, go on; but for the present purposes, suffice it to say that by the very early nineteenth century there was an established discourse of nerves and nervousness that was commonly in use and figured regularly in fiction and popular discourse from the period. We have inherited the remnants of that discourse; and even though characters like Mrs. Bennet may seem not to exist any longer, we still speak their language. The use may have passed into the realm of metaphor, but English speakers are still at home describing ourselves as “nervous” about an upcoming event, for example. Similarly, it is not at all odd to claim that some obnoxious music “gets on my nerves” or that “I am on my last nerve”. Rather, we are still quite comfortable using phrases like “nervous breakdown”, “nervous wreck”, and the like, in an era where our actual nerve cells are not really what we consider to be at issue. Regarding this inherited language, there are two things should be kept in mind while reviewing the history elaborated in the following pages.

First, it is important to consider that literary representations of characters like Mrs. Bennet, although comical or annoying, are very much representations of human suffering, and the language that we have inherited from that time is still very much an indicator of pathos, at least weakly so. Despite the fact that nervous individuals may have been hard to tolerate or get along with, their suffering was very real regardless of the extent to which their sensations and experiences were “real” or imagined, self-induced or caused by something outside their control. Today we use their language to describe our own bodily sensations when we no longer feel tranquil, calm, or within our normal range of comfort. Unfortunately, it is easy to forget that at one time such terms could be used to refer to experiences that were often far more severe or complicated than the metaphorical indicator of discomfort it has become in English and some other European languages.

Second, it should be pointed out that the inheriting of nerve metaphors described above is simply not the same when it comes to the quintessential nervous disorder, neurasthenia. In fact, it is probably safe to say that many native English speakers have never heard of the concept, much less are they likely to employ it as part of their vocabulary, even metaphorically. Of course, some languages may refer to the universal experience of “feeling nervous” without even making

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101 (pp. 50, 57, 87, 93, 140, 144, 175, 177, 186, 249, 281, 302, 327)
reference to nerves at all. Such is the case with Chinese, Japanese, and Hindi, for example. Interestingly in the Chinese context, although there is no meaningful sense that feeling nervous about something could elicit the idea of feeling *shenjing*, it is conceivable that feeling very nervous or anxious about something could, at the very least, elicit a reference to neurasthenia. In such a case, we would find usage to be the exact opposite of English idiom. Some reasons for this difference with respect to the English language cultural/linguistic context will be addressed briefly towards the end of this chapter and in other chapters. More importantly, however, it is worthwhile to look at some of the circumstances that gave rise to the popular discourse of nerves and nervousness generally, and to neurasthenia in particular. These modes of discourse are an important development in the psychosomatic/somato-psychic understanding of the human person as it has developed in the field of medicine around the world. It is therefore my aim in this chapter to introduce a rudimentary background that can serve to contextualize both nerves and neurasthenia, the ultimate aim of which, in the following chapters, is to consider neurasthenic discourse in China and Japan as a specific development in, and contribution to, psychosomatic medicine. This chapter is divided into five main sections:

1) The first section is an attempt to provide some background to the earliest writings on nerves or nervous ailments. In the seventeenth century, there was as an increasingly forceful challenge to classical humoral theories of specific diseases, which infiltrated both the medical and popular lexicons, making nerves and nervousness fashionable.

2) In the second section, I briefly describe the increasingly negative light in which nervous ailments began to be viewed, from the mid-eighteenth century until the late nineteenth century. I will also explain some of the changes in how the pathology of nervous diseases was conceptualized. This

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102 For example, no one would ever say, “我感覺很神經” or “我覺得很神經” or “有一點神經” when the intended meaning is “feeling nervous”. The nerve metaphor simply does not hold in the Chinese language case. However, the nerve metaphor would hold if the intended meaning was that the speaker was feeling “crazy” or “out of sorts”. Instead, however, the normal way of speaking would be to say “覺得/有一點緊張”, etc. Interestingly, if the situation was one of prolonged 緊張, it is conceivable that the nerve metaphor could kick-in with a reference to 神經衰弱. The point is simply that reference to feeling “nervous” never makes use of the term “nerve” in Chinese, while the term “neurasthenia” could conceivably be used. The opposite is true in English language idiom. The reasons for this difference are historical/cultural and will not be addressed in any single section of this project, but will be addressed holistically by the entirety of the project.

103 In both modern Chinese and Japanese, psychosomatic medicine is referred to as 心身医学 (C: xinshen yixue; J: shinshin igaku).
includes a summary of the growing notion at that time that there are certain diseases without any describable physical lesion; these came to be termed “functional lesions”.

3) The third section begins with George Beard’s popularization of the term neurasthenia and its spread in both the United States and Europe.

4) In the fourth section, I will discuss some of the controversy pertaining to neurasthenia’s legitimacy as a clinical concept in the decades after 1869 and offer possible reasons for its decline in the early twentieth century.

5) I will conclude the chapter with a brief discussion of how the western origins of “nervous” discourse are important for understanding Arthur Kleinman’s model of SJSR and somatization in China.

The material in this chapter has been the subject of numerous book-length studies in the history of medicine, including detailed accounts of the various transitions in historical schools of medical theorizing. I will briefly refer to some of the changes in thought and the social contexts that coincide with those changes when they serve to highlight a new way of thinking about nervous disease. This is the case, for example, with the various ways of defining nervous system lesions and the increase of nervous disorder, but I do not cover those issues in detail as I have chosen instead to point the reader to other sources. In addition to a broad secondary literature, I also make wide use of numerous primary sources whenever I think it helpful, which is often.

2.1 The Rise of Nervous Discourse through the Mid-Eighteenth Century

It is not within the scope of this project to provide a detailed history of the epistemological transitions that took place with respect to the field of medical science now called psychiatry. However, it should be noted that nervousness and nerve discourse represent a paradigm shift away from more classical theorizing on emotional complaints. As other scholars have pointed out, prior to this shift, disease conditions were theorized on the basis of classical models inherited from Hippocrates and Galen. The etymologies behind some of the major illness categories of

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antiquity also serve to illustrate this point. For instance, some etiological assumptions can be inferred from the disease names melancholy (Greek *melanos-khloe* “dark bile”), hypochondria (*hypo-khondriakos* “below the cartilage/lower abdomen”), and hysteria (*hystera* “womb/uterus”), all three of which fell within the rubric of nervous disease, once the concept was developed. One point that should be uncontroversial is that, even though these categories relied on humoral theory and the notion of diseased abdominal organs\textsuperscript{105} to account for the maladies now considered psychiatric, they ought to be considered psychosomatic theories insofar as they readily recognized the effect that such “bodily” diseases had on emotion, thought, and mood. Furthermore, there had long been at least some recognition, dating back to Galen and Hippocrates, that emotion, thought, mood, and the passions could also affect very detrimental changes on various parts of the body.\textsuperscript{106} However, as should slowly become clear, body/thought theorizing historically took place within a continuum wherein medical and public opinions swung between extremes of somatic and psychic causation.

The fear, sorrow, worry, indigestion, flatulence, belching, headaches, irregular pulse, difficulty breathing, insomnia, and other disturbances that were indicative of diseases of the hypochondrium had been attributed, since Hippocrates and Galen, to the various disregulations of biles and harmful vapors, which resulted from ailing organs that sat below the rib-cage (hence the Greek name). Robert Burton’s famous 1621 work, *The Anatomy of Melancholy*, is the most famous and representative example of the type of theorizing that went into explaining such ailments during the Renaissance and prior to the introduction of nerve discourse.\textsuperscript{107} “It may properly be called the first psychiatric cyclopaedia for nearly one thousand authors are cited, about half of them medical men”.\textsuperscript{108} The diverse array of causal forces that Burton took into consideration in his work, all of which fell within humoral discourse, was not uncommon to works pertaining to similar illness descriptions in the more than 1500 years before him, as well as for at least 100 years after his

\textsuperscript{105} “Hypochondriacal melancholy”, for example, was coined to explain melancholy due to secretions coming from diseased spleen or other organs below the rib-cage. See: Lawrence Babb, *The Elizabethan Malady: A Study of Melancholia in English Literature from 1580 to 1642* (Michigan State University Press, 1965).


death.\textsuperscript{109} Even though the mind-body relationship worked causally in more than one direction, Burton pre-dated any discussion of the nervous system as was later to come to light from dissection and anatomical study.

In the second century, Galen systematized the views of Hippocrates. In this systemization, classical medical theory maintained that, among the four humors (blood, yellow bile, black bile, and phlegm), black bile accounted for disease conditions in a number of ways. “One of these was a primary disease of the brain, with only a local excess of black bile. In the other two types the brain was affected only secondarily. In one of the secondary forms . . . melancholia hypochondriaca, the primary disease was in the upper abdominal area with the resultant flatulence and digestive disturbances”.\textsuperscript{110} Black bile was thought to be filtered out of the blood via the liver, gaining its thickness and pathogenic abilities. It was then believed to undergo transformations in the spleen before being changed either into nutrients or elements of blood, after which, relocation to the stomach could either aid digestion or cause stomach disturbances. Ultimately, evaporations of the humor in the stomach could result in vapors that might later rise to the brain. If the spleen or liver failed to do its job for whatever reason, harmful vapors could be the end result; a disordered stomach could also initiate the disease process, and the numerous titles of medical texts published on the topic bewray these theoretical commitments.\textsuperscript{111} The classical, humoral views that were summarized by Burton were soon to enter decline as physicians attempted to incorporate growing anatomical understandings that had been on the rise at least since the mid-1500s.\textsuperscript{112}

From the middle of the eighteenth century, there appears to be an increased interest among physicians to find the source of certain medical complaints in the anatomical system of the nerves and brain. This shift can be traced, along with the growing number of challengers to the classical etiologies, through Thomas Willis\textsuperscript{113} (1621–1675), who introduced the term “neurology”, Thomas

\begin{footnotesize}
\begin{enumerate}
\item Stanley W. Jackson, \textit{Melancholia and Depression: From Hippocratic Times to Modern Times} (Yale University Press, 1986). See description on p. 43–44.
\item Ibid., 1–103. Jackson traces the long history of such explanatory efforts in greater detail, and the first hundred pages cover ancient history through the 1600s.
\item For examples of titles indicating such theorizing, see Blackmore and Cheyne.
\item Andreas Vesalius published his \textit{De Humani Corporis Fabrica} (On the Fabric of the Human Body) in 1543. The work included a chapter on Galen’s errors. Many works followed, with increasing gains in understanding.
\item Willis’s 1667 text, \textit{Essay of the Pathology of the Brain and Nervous Stock: In which Convulsive Diseases are Treated of}, is a good example of the shift in thinking manifesting in book titles themselves.
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Sydenham (1624–1689), Sir Richard Blackmore (1653–1729), Nicholas Robinson (1697–1775), George Cheyne (1671–1743), Robert Whytt (1714–1766), and to William Cullen (1712–1790), who coined the term “neurosis”. Other scholars have rigorously documented the changing understandings of melancholy, hypochondria, and related distempers across the writings of these and contemporaneous authors, and it is not necessary to repeat that effort here. Instead, a brief summary will suffice before considering neurasthenia.

Scholars differ as to who most influenced the popularization of “nervous disease” as a concept. For example, Heather Beatty has suggested that, “Nervous disease first achieved widespread attention as a nationally significant disorder early in the eighteenth century, with the work of the Bath physician, George Cheyne”, whose 1733 text is titled *The English Malady; or, A Treatise of Nervous Diseases of All Kinds, as Spleen, Vapours, Lowness of Spirits, Hypochondriacal and Hysterical Distempers*. Lopez-Pinero, on the other hand, argues that “the series of monographs” published during the early eighteenth century on the topic of nervous disorders “culminated with the publication of a book by Robert Whytt”, in 1765, titled *Observations on the Nature, Causes and Cures of those Disorders which are commonly called Nervous, Hypochondriac, or Hysteric*. According to Lopez, it was Whytt’s text, published more than thirty years after that of Cheyne, that had the stronger influence. He claims, “Nervous disease became a fashionable diagnosis because of Whytt’s reputation”. The apparent difference is probably a minor one that can be resolved by considering the different audiences for the texts in question; Whytt had a stronger influence on other physicians while Cheyne was likely to have influenced a lay readership, as can be inferred from discussions to follow below.

Hypochondria, hysteria, melancholy, and their varied symptoms had been referred to as “nervous” conditions at least since the first decade of the eighteenth century, and discussions about

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118 Ibid., 10.
the role of the nervous system in explaining classical disease entities began even sooner.\textsuperscript{119} As early as 1667, London physician, Thomas Willis, wrote his \textit{Essay of the Pathology of the Brain and Nervous Stock: In which Convulsive Diseases are Treated of}, which indicated by its title the aim of focusing on the role of the brain.\textsuperscript{120} Although still deeply entrenched in seventeenth century and classical thought, Willis rejected the “wondering womb” conception of hysteria, as well as the idea that hysteria was specific to women, arguing that hysteria was the result of the brain and of the nerves that ran from the brain to the rest of the body.\textsuperscript{121} Willis employed both Galenic notions alongside knowledge gained from dissection and anatomy, in a revolutionary attempt to account for classical disease conditions like melancholy:

\begin{quote}

Sometimes the Melancholy, being disturb’d in the spleen, conveys thence the passion to the brain, whence disorderly and hypochondriacal fancies happen: And on the contrary, when violent Passion of the mind, occasionally rais’d within the brain troubles the Spirits residing in it, the impression given the fancy, is convey’d to the spleen by the course and successive affect of the spirits, lying within the nerves.\textsuperscript{122}

\end{quote}

Richard Blackmore’s 1725 monograph, \textit{A Treatise of the Spleen and Vapours, Or Hypochondriacal and Hysterical Affections}, mentions the term “nervous” at least thirty-five times, usually in the context of irritated nervous-fibers or the otherwise “tender and delicate constitution of the nervous system”.\textsuperscript{123} Blackmore maintained that patients in his day were embarrassed by the diagnoses of hysteria and hypochondria due to the odd ideas such patients were expected to hold, as well as the derision and contempt that they met socially.\textsuperscript{124} It was the notion of a tender nervous system that Cheyne capitalized upon, when in 1733, he postulated that a third of all conditions of complaint in England were “nervous” in nature (preface, p. ii).\textsuperscript{125} Cheyne’s text serves as a famous example of attributing various medical phenomena, later to fall within the purview of psychiatry,

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\textsuperscript{119} Ibid., 5.  \\
\textsuperscript{120} Thomas Willis, \textit{Essay of the Pathology of the Brain and Nervous Stock: In Which Convulsive Diseases Are Treated of} (Dring, 1684). Willis was the first to introduce the term “neurology”.  \\
\textsuperscript{121} Harry Whitaker, C. U. M. Smith, and Stanley Finger, \textit{Brain, Mind and Medicine: Essays in Eighteenth-Century Neuroscience} (Springer Science & Business Media, 2007), 322.  \\
\textsuperscript{122} Thomas Willis, \textit{The London Practice of Physick, Or The Whole Practical Part of Physick} (Thomas Basset and William Crooke, 1685), 311.  \\
\textsuperscript{123} Richard Blackmore, \textit{A Treatise of the Spleen and Vapours, Or Hypochondriacal and Hysterical Affections: With Three Discourses on the Nature and Cure of the Cholik, Melancholy, and Palsies} (J. Pemberton, 1726), 30.  \\
\textsuperscript{125} George Cheyne, \textit{The English Malady; Or, A Treatise of Nervous Diseases of All Kinds, as Spleen, Vapours, Lowness of Spirits, Hypochondriacal and Hysterical Distempers}, 1733.
\end{flushright}
to the particular romanticized aspects of a certain class. For Cheyne, it was the refined sensibilities of the upper-class English who most suffered from the confluence of delicate nervous systems, an unfavorable climate, and the luxurious living available to advanced, civilized society.

Roy Porter suggests that, “by characterizing nervous debility as the archetypal malady of the elite, Cheyne seemed to imply that to be truly fashionable, it was necessary to display at least a little mental abnormality or emotional anxiety”.126 Following the example set by Blackmore’s reference to the “English Spleen” and Burton’s reference to the melancholic suffering of scholars, Cheyne was able to combine and popularize the notion that the refined life of those exceptional higher classes facilitated the distempers that were common to susceptible people with delicate

126 Porter, George Cheyne, xi.
nervous systems. In his chapter on exercise for nervous distempers, he wrote that “the common division of mankind, into Quick thinkers, Slow thinkers, and No thinkers, is not without foundation in nature and true philosophy. Persons of slender and weak Nerves are generally of the first Class: the Activity, Mobility and Delicacy of their intellectual Organs make them so”. These ideas, repeated in the advertisement for the work, along with Cheyne’s overall project, are considered to be one of the major contributions to the popularity of nerves as they figured in the language of the period. The same can be said for literature of sensibility, or the sentimental novel, which had its beginnings with Cheyne’s close friend Samuel Richardson, author of the epistolary novels *Pamela* (1740) and *Clarissa* (1748). The language and literature of the era were inseparable from the romantic discourse of nerves, which claimed exceptional sensibilities for those suffering from nervous disease.

2.2 Nerve Discourse from the Late Eighteenth Century to 1869

Such popularization of nervous diseases may have been one motivation behind Robert Whytt’s 1764 publication of *Observations*. The Edinburgh professor was weary of the haphazard use of “nervous” as a diagnosis and set about to offer an objective categorization of such illnesses, but in the end he concluded on the “impossibility of fixing a certain criterion, by which nervous disorders may be distinguished from all others”. Nevertheless, he was able to provide a list of symptoms by which physicians could attempt to distinguish between the complaints of the “simply nervous”, “hysteric”, and “hypochondriac”. More importantly, even though he did not make the

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127 In the preface to his *Treatise* on page vi, Blackmore states that the “English spleen, as I have now named it, and as I have described it in the following pages, is comparatively but seldom found among the inhabitants of other countries”. Richard Burton dedicates a chapter to the melancholy of scholars, and defines it as a cause on page 201 of volume one of his *Anatomy*.


130 In fact, Stephanson offers a scathing critique of numerous literary theorists, some very respected (e.g., Eagleton), who see as having used “the text to score points for a particular literary-critical methodology or political-sexual ideology [and] sometimes tended to obscure or deflect attention from the novel’s historical contexts and circumstances, or at least to make history secondary to the needs of current critical theories” (268). Unfortunately, she does not go far enough. She fails to point out that it really does appear that such abuse of texts, without any concern for this type of infidelity to the intellectual/historical backgrounds of their creation and reception, is seemingly ubiquitous in the humanities.

evaluative judgments regarding a link between increased levels of civilization and nervous disorder that were common to Cheyne and the popular understanding, he did confirm the idea that nervous diseases were more likely to occur in those persons with more delicate nervous systems. Such patients experienced exaggerated or extreme sensations arising from relations of “sympathy” between differing parts of the body. Sympathy that became pathological could lead to the nervous diseases.

Since Hippocratic times, “sympathy” was a recognized phenomenon whereby disparate parts of the body were found to share relationships such as consensual pupillary dilation in the eyes, pain at a distance (e.g., pain in the face from a rotten tooth), or vomiting associated with inflammation in the kidneys. In the first chapter of his Observations, titled “Of the Structure, Use, and Sympathy of the Nerves”, Whytt set out to establish nervous disease as a legitimate object of medical concern by arguing that both “general” and “specific” sympathies in the body were inseparable from sensibilities that were made possible only by the nerves (as opposed to something like humoral interaction). In 1681 Thomas Willis had already proposed a possible explanation for how there might be functional (sympathetic) interactions across disparate parts of the body. Specifically, Willis had identified the “intercostal” nerve structure, which was later named the Grand Sympathique (and is known as the sympathetic trunk today). In opposition to Willis’s model, Whytt argued very strongly that the sympathy attributed to the “intercostal” could not arise merely from nerve anastomoses between organs. Rather, he believed that the role of the intercostal in creating sympathy had to be mediated via nerves’ interaction with the spinal “marrow” and the brain. This overlooked detail of Whytt’s is arguably the first brain-body explanatory model accounting for somatic complaints, a topic which will be addressed in the next chapters.

The last major figure in the eighteenth century who worked to establish the seriousness of nerves in the research of “physic” was William Cullen. His writings are cited by historians for having coined the term “neurosis” in his Synopsis Nosologiae Methodicae (1769), but he also popularized a school of thought, now known as “neural pathology”, that claimed the central place for the nervous system in all disease processes and described a nerve “power” or force that

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133 Whytt, Observations. Chapter 1, Section 14. He argues this in part by showing that, anatomically, there simply are no such anastomoses to be found for the types of sympathetic relations listed.
originated in the brain and circulated throughout the nervous system.\textsuperscript{134} His nosology was less well accepted, but it is worth mentioning briefly since later advances in cellular pathology slowly dismantled nosological attempts like Cullen’s.

Cullen’s classification provided discreet categories for “neuroses” that were considered to be general diseases of the nervous system. These included reduced involuntary movements (e.g., reflexes), reduced voluntary movements (e.g., comas), spasms (abnormal muscle or fiber movements), and “vesaniea” (Latin \textit{ves} “not” + \textit{saniea} “sane”) or altered judgments/mental derangement.\textsuperscript{135} Hypochondria fell under the category of diminished involuntary movements, hysteria fell under spasms, and both melancholia and mania fell under vesaniea. A simple glance at these categories makes clear that numerous phenomena could be classified under Cullen’s “neuroses” that are not presently considered to be psychiatric in any sense. In fact, Cullen included diarrhea, diabetes, whooping cough, and other conditions under his classification of “spasmi” neuroses in his \textit{First Lines of the Practice of Physic}.\textsuperscript{136} This seemingly odd classification was the result of Cullen’s desire to interpret clinical phenomena through the etiological model of general, nervous system causation. When seen this way, it makes sense that diarrhea, for example, would be considered a spasmodic disorder of nerves that causes the excessive contraction of the bowels. This intended meaning of “neurosis” was quite literally a disease of the nervous system. A century later, the changing views in physiology brought about by cellular pathology established the belief that most of Cullen’s neuroses were not really nervous system pathologies at all. Before cellular pathology, however, nervous diseases were to move even further away from being fashionable maladies, while becoming increasingly associated with growing social problems.

The end of the eighteenth and the beginning of nineteenth century saw some changes in the way nervous diseases were viewed. While they had been somewhat romanticized in early eighteenth century medical publications and in the period’s literature, the close of the century brought a more pessimistic view. Whytt and Cullen had attempted dispassionate scholarship on the topic in the mid-eighteenth century, but nineteenth century physicians had very strong opinions


\textsuperscript{135} For a detailed discussion on Cullen’s taxonomy see: Pinero, \textit{Historical Origins of the Concept of Neurosis}, 11–15; Bowman, “William Cullen (1710–1790) and the Primacy of the Nervous System.”

\textsuperscript{136} William Cullen, \textit{First Lines of the Practice of Physic: By William Cullen}, vol. IV (Bell & Bradfute, and William Creech; and G. G. and J. Robinsons, and H. Murray, 1796), 54,86.
about the moral decline that accounted for nervous ailments believed to be on the rise. Thomas Trotter, a Scottish naval physician, published a text on the topic in 1807, the position of which, although resonant with earlier ethnocentric theories of the diseases, cannot be mistaken as anything other than demeaning. Because Trotter attempted to describe the nervous disorders as best as he could, given the developments within medical practice, he offered a lengthy definition of what the categories had come to mean; I quote him at length.

Nervous feelings, nervous affections, or weak nerves, tho’ scarcely to be resolved into technical language, or reduced to a generick definition, are in the present day terms much employed by medical people, as well as patients; because the expression is known to comprehend what cannot be so well explained. An inaptitude to muscular action, or some pain in exerting it; an irksomeness, or dislike to attend to business and the common affairs of life; a selfish desire of engrossing the sympathy and attention of others to the narration of their own sufferings; with fickleness and unsteadiness of temper, even to irascibility; and accompanied more or less with dyspeptic symptoms, are the leading characteristics of nervous disorders; to be referred in general, to debility, increased sensibility, or torpor of the alimentary canal.\textsuperscript{137}

This definition does not refer to the classical categories of hysteria, hypochondria, or melancholy, and the terms only appear in the larger text four, four, and two times respectively, without any explanation of their intended meaning. It seems unlikely that the historic categories had lost their understood meaning, but the vagueness of nervous debility made their delineation less necessary by the time of Trotter’s writing in England. Among the interesting claims in the text, however, three stand out as being worthy of note.

First, Trotter continued to perpetuate the nationalist discourse that was so prominent in Cheyne. Regarding international comparisons Trotter wrote that, “It is probable the other countries of Europe do not exhibit such general examples of these diseases; as many of their causes are to be traced to the peculiar situation of Britain; its insular varieties of climate and atmosphere; its political institutions and free government; and above everything, its vast wealth, so diffused among all ranks of people”.\textsuperscript{138} The organization of his book also evinces this perspective, as it first

\textsuperscript{137} Thomas Trotter, \textit{A View of the Nervous Temperament: Being a Practical Inquiry Into the Increasing Prevalence, Prevention, and Treatment of Those Diseases Commonly Called Nervous, Bilious, Stomach and Liver Complaints, Indigestion, Low Spirits, Gout, &c} (Wright, Goodenow, & Stockwell, and, 1808), 12.

\textsuperscript{138} \textit{Ibid.}, xiii-xiv.
discusses the health of the “savage”, which is compared to the nervous diseases that occur among “civilized mankind”. In this way, Trotter claimed for civilization the status of an indirect cause of nervous ailments. Second, although he maintained the nationalist outlook, he denied that the diseases were indicative of any special status intranationally, since he claimed that the “nervous ailments are no longer confined to the better ranks in life, but [are] rapidly extending to the poorer classes”. In other words, even though the least estimable in British society were still seen as far superior to uncivilized savages (international comparison), the nervous ailments were nothing to be proud of insofar as they also befell the lowest social classes (intranational). This raises the issue of Trotter’s third claim regarding the more direct causes of nervous ailments. Specifically, he claimed that nervous weakness, more than any other disease, “is induced by indolence, by sloth, and want of active motion” and it “puts on the form of every other complaint, and becomes one of the greatest stings to human happiness”. He thought that a “life of indolence . . . led under luxuriant diet, joined to the liberal use of fermented liquors” was one of the representative examples of what was causing the nervous ailments among his countrymen. In other words, nervous ailments had begun to lose their former glamor.

Historian Heather Beatty has convincingly argued that by 1800, British nervousness had become “a disease of the masses”, “a disease of the weak willed”, and “a disease of the softer sex”; and views similar to those of Thomas Trotter were increasingly shared in magazines, medical books, and newspapers. She points out that “increasingly negative attitudes toward nervous women were also reflected in novels of the eighteenth century. Whereas the fainting heroines in the sentimental literature of the early part of the century were celebrated for the strength of their debilitating sensibility, the heroines of nineteenth-century novels exhibited stronger command of their deep feelings”. This shift towards growing impatience with the nervous sufferer meant that some physicians felt it necessary to counterbalance the growing harshness of popular attitudes, and one such example can be found in John Reid’s (1776–1822, English physician) 1821 monograph, Essays on Hypochondriasis and other Nervous Affections. Reid wrote: “Nervous

139 Ibid., viii.
140 Ibid., xiii.
141 Ibid., 66.
142 Ibid., 66–7.
144 Ibid., 164. Hence the ridiculing of the nervous Mrs. Bennet in Austen’s Pride and Prejudice.
diseases, from their daily increasing prevalence, deserve, at the present time, a more than ordinary degree of attention and interest on the part of the medical practitioner. Yet . . . we often act upon the ill-founded idea that such complaints are altogether dependent upon the power of the will”. While he did not deny the common notion that nervous diseases continued to proliferate, Reid did take issue with the idea that the individual sufferer could ameliorate their ailment by an act of will. He went on to criticize those who suggested that the plight of nervous patients resulted from their own “imaginary sorrow”, which would merely require a change of perspective about their own lives. Reid chose not to attribute blame to the sufferer. On the surface, this view seems at odds with the likes of Thomas Trotter and others who attributed the ailments to the lifestyle, choices, and mentality of the patient. As mid-century approached, however, new ideas were further complicating how nervousness was understood.

The situation outside England at the turn of the nineteenth century was not much different. For example, Benjamin Rush, father of American psychiatry and student of William Cullen, stated in 1774 that “the hysteric and hypochondriac disorders, once peculiar to the chambers of the great are now to be found in our kitchens and workshops. All these diseases have been produced by our having deserted the simple diet and manners of out ancestors”. The belief that the nervous ailments were becoming increasingly common among the lower classes seems to have become the norm by 1800, and theories on social decline and degeneracy were not uncommon in political theory, criminology, and medicine. However, there were some changing or disparate views regarding the anatomic mechanisms underlying nervous disorders, and these differences gave rise to vocabulary that was to facilitate how physicians conceptualized the variety of disorders. Historians of psychiatry seem generally to agree that, by the end of the eighteenth century, three

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145 John Reid, *Essays on Hypochondriasis and Other Nervous Affections* (Longman, Hurst, Reese, Orme, and Brown, 1823), 7. Essay II treats this issue in detail, including how absurd it is to tell a nervous patient to be cheerful and alert; he rejects that they could will such changes to occur.

An analysis of social decline theories and their relationship to ethology, and eventually eugenics, is beyond the scope of this project. Such a discussion is very important in the context of early twentieth century Japan, however, and there is a large literature on the subject.
distinct schools of thought had developed regarding the concept of neurosis. These were the naturphilosophie, the anatomo-clinical, and the pathophysiologica

A detailed account of the changes in these historical schools can be found in Lopez-Pinero. Though an oversimplification, it is sufficient to categorize naturphilosophie as an outgrowth of German romantic philosophy that was not involved in detailed anatomic examinations of clinical phenomena. The anatomo-clinical school was popularized by Pinel and Georget, and can be characterized by its focus on the search for anatomical lesions. According to Lopez-Pinero, it was this shift away from symptom as central focus, toward anatomical lesion, which became the basis of medicine One can summarize the period by stating that the priorities of the anatomo-clinical school led to the identification of increasing numbers of structural lesions via physical examination of patients both in life and post-mortem. However, it became clear to many physicians that some diseases, especially those traditionally considered to be “nervous” diseases, persisted in the apparent absence of any structural, anatomical lesion. This fact raised serious problems for how such diseases should be conceptualized. Highlighting this tension, Hodgkiss has argued that the anatomo-clinical school gave rise to the concept of lesion-less symptoms at the turn of the century with the coining of new terms. In his Nosographie Philosophique of 1798, Philippe Pinel, one of the fathers of modern psychiatry, appropriated and altered the meaning of Cullen’s term, making the absence of any tissue lesion central to his own concept of “neurosis”. Three years later in 1801, physician and anatomist Francois Chaussier introduced the term “neuralgia” to describe cases of pain in the absence of any lesion. The pathophysiologica

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149 Pinero, Historical Origins of the Concept of Neurosis.

150 Ibid., 44.

151 Hodgkiss, From Lesion to Metaphor, 34.

152 Pinero, Historical Origins of the Concept of Neurosis, 59.
physiopathological view of neurosis, before moving on to discuss the arrival of neurasthenia as a concept.

The tenth chapter of Michel Foucault’s *Birth of the Clinic* appears to credit the French physician Francois Broussais (1772–1838) with initiating the resolution of the problem of lesionless diseases, which plagued the anatomo-clinicians’ attempts to correlate physical lesion with pathology.153 The context of Foucault’s chapter is more closely associated with the ontological status of fevers and inflammation, but as Hodgkiss points out, Broussais was also interested in the problem of aches and pains absent structural lesion.154 While it is not necessary to attend to Broussais’s theories in detail, it is important to note that his predominant focus was on the concept of “irritation” in specific organs, and the transmission of that irritation by the nerves. It should also be mentioned that his move towards irritation as an explanatory concept was not without precedent, as historian of psychiatry Edward Shorter has pointed out previously.155

Unfortunately, it appears that Broussais overemphasized gastroenteric irritation as a cause of many, if not most diseases, a fact for which he has been criticized. Nevertheless, his conceptualization “that disease was not an ontological ‘other’ but the result of altered functions—too much or too little of regular processes”—revitalized the concept of “irritation” as a central characteristic of pathology.156 Before turning to further developments in such functional conceptualizations of nervous diseases, it is worth quoting a section of his *A Treatise on Physiology Applied to Pathology*, which speaks of “the manner in which the Exercise of the Intellectual Faculties disorders health”, since his description is very much in concert with the descriptions of neurasthenia that were to come only a few decades later. He wrote:

In the lowest grade of the intellectual operations . . . sudden perturbations never arise . . .

It is thus, that purely intellectual labours, without any mixtures of passions, such as the abstract sciences, — mechanics, the forced exercise of memory, — the labours of the copyist, the analyst, or the historian, philology, bibliography, — in a word, every thing which only exercises thought by requiring a lively and constant attention, keeps up in the encephalon a state of vital erection by which it is sensibly transformed into a permanent

focus of irritation. Under these circumstances, the head becomes heavy and painful; there is an inclination to sleep, or else an obstinate state of wakefulness is established: and inflammation of the brain, either acute or chronic, as well as haemorrhages of this organ, are on the point of being developed . . . In time, the same irritability is established in the ganglionic nerves; and the movements of the viscera as well as those of the vascular apparatus in general, become disordered under the influence of the slightest causes . . .

Another modification of the system, is sometimes associated with the cerebral irritation produced by the excessive exercise of thought. It is a state of debility in the muscular apparatus, a sluggishness of digestion, accompanied with costiveness and with a remarkable languor in the cutaneous transpiration. Hence result a multitude of evils: for food, by remaining in the upper regions of the digestive canal, finally develops there an irritation.\textsuperscript{157}

The physiopathology approach to finding the source of disease in a physiological process rather than an anatomical entity continued into the mid-nineteenth century. This can be seen in physicians’ continued theorizing about function rather than merely focusing on discrete structures. One of the interesting details of this period is that British medical writing seems to have done away with much discussion of neurosis for the next fifty years. Instead, the concept of irritation was applied to nervous ailments in an attempt to localize the source of disease without reference to a lesioned tissue. Lopez-Pinero has suggested that from the 1820s, “the clinical and pathological phenomena to which the word neurosis referred, continued being debated under different names, such as ‘Spinal irritation’ or ‘Reflex functional nervous diseases’, which were but explanatory images created by British physiopathology”.\textsuperscript{158}

The subjects of “spinal irritation” and “reflex functional nervous diseases” have been commented on in detail by Shorter, Hodgkiss, and Lopez-Pinero.\textsuperscript{159} The development of the former model seems to have facilitated the introduction of the latter, and they can both be summarized by the claim that local irritations in organs or in the spinal nerves (or the spine itself) can give rise to the experience of discomfort, pain, or pathological symptoms without the evidence of any specific discrete lesion or inflammation. Development of this idea led to the notion that spinal irritation could reflexively be transmitted to distant parts of the body in a route mediated by

\textsuperscript{157} François Joseph Victor Broussais, \textit{A Treatise on Physiology Applied to Pathology} (Carey & Lea, 1832), 203–4.

\textsuperscript{158} Pinero, \textit{Historical Origins of the Concept of Neurosis}, 64.

the spine and its nerve pathways, and Hodgkiss suggests that it was the “explanatory utility of irritation as invisible lesions” that led to its use among British authors.\textsuperscript{160} Among the exegetes of this theory was Benjamin Travers (1783–1858), surgeon at St. Thomas Hospital, London. In 1826 Travers published a large monograph on the topic of spinal irritation titled, \textit{Inquiry Concerning that Disturbed State of the Vital Functions Usually Denominated Constitutional Irritation}, and nine years later (1835), he published a second volume on the topic.\textsuperscript{161} Travers defined local irritation as an “alteration in the habitual and proper sensation or action of a part: as a depravation or suspension of function in an organ of sense” or as “pain, unattended by any other sign of inflammation. The irritable joint, breast, testicle, (etc.)”, and it is surprising to consider how contemporary conceptions of categories like “irritable bowel syndrome” have hardly moved past Travers’s attempts at explanation for similar phenomena.\textsuperscript{162}

One of Travers’ contemporaries and the founder of Leeds School of Medicine, Thomas Pidgin Teale (1800–1867), helped in promoting the notion of spinal irritation with his 1829 publication of \textit{A Treatise on Neuralgic Diseases, Dependent Upon Irritation of the Spinal Marrow and Ganglia of the Sympathetic Nerve}. In regard to the variety of visceral pains, bodily weaknesses and discomforting sensations claimed by so many patients, Teale wrote:

\begin{quote}
I have for a few years been in the habit of treating many of these nervous affections as diseases of some portion of the spinal marrow or ganglia: and have been still further confirmed in my opinion, by the frequent and almost uniform co-existence of tenderness on pressing some portion of the vertebral column, and the circumstance of the tender portion of the spine being in the particular situation where the nerves of the affected part originate.\textsuperscript{163}
\end{quote}

It is not clear the extent to which this line of thinking was later to contribute to the development of the practice of chiropractic, but it seems to have had some influence on a very hotly contested issue in the United States and Britain. From the mid-nineteenth century, there was

\textsuperscript{160} Hodgkiss, \textit{From Lesion to Metaphor}, 52.
\textsuperscript{161} Benjamin Travers, \textit{An Inquiry Concerning That Disturbed State of the Vital Functions Usually Denominated Constitutional Irritation} (H. Stevenson, 1826); Benjamin Travers, \textit{A Further Inquiry Concerning Constitutional Irritation and the Pathology of the Nervous System} (1835).
\textsuperscript{162} Travers, \textit{An Inquiry Concerning That Disturbed State of the Vital Functions Usually Denominated Constitutional Irritation}, 35.
\textsuperscript{163} Thomas Pridgin Teale, \textit{A Treatise on Neuralgic Diseases, Dependent upon Irritation of the Spinal Marrow and Ganglia of the Sympathetic Nerve} (1829), 4.
a growing debate in medical literature over the legitimacy of litigants’ claims to have been injured in railway accidents. Eric Caplan has written about the instrumental role of “railway spine” in the conceptual development of psychotherapy in the USA, and he sees it as one of the pivotal debates that facilitated a move toward “psychogenic notions of causality” that would dominate the early twentieth century.164

In 1866 the English surgeon John Eric Erichsen delivered a series of lectures on the phenomenon he called “concussion of the spine”. His motivation in investigating the issue in part arose from his observance that “there is no class of cases in which medical men are now so frequently called into the witness-box to give evidence in courts of law, as in the determination of the many intricate questions that often arise in actions for damages against railway companies for injuries alleged to have been sustained by passengers in collisions on their lines; and there is no class of cases in which more discrepancy of surgical opinion is elicited than in those now under consideration”.165 The discrepancy of opinion arose not in the instances where there were clearly physical lesions such as bone fractures or other obvious injuries; rather, Erichsen set out to explain a host of physical and emotional disturbances that had no obvious causal relationship to the railway accident. The lectures are organized beginning with obvious and serious trauma to the spine (i.e., actual spinal fractures or death) and moving progressively toward explaining concussion of the spine from slight injury or from shocks, twists, and wrenches of the spine. He accomplished his argument by presenting a series of fourteen cases of spinal concussion, a typical example of which is Case Eleven. Because of its similarities both to the ailments described already and to those that follow below, it is worth mentioning here in brief before concluding this section.

A fifty-year old, healthy man was in a railway collision in 1865 without any evidence of physical injury despite being violently shaken during the accident. He proceeded on his journey another seventy miles only to find himself feeling shaken and confused upon arrival. Being unable to attend to business matters, he sought medical help progressively over the next year as his symptoms continued to worsen. When Dr. Erichsen saw him in 1866 the man had lost twenty-five pounds, was weak and unable to walk one-quarter of a mile without fatigue, and was still unable to attend to any business. His friends and family described him as an “altered man”. He suffered

165 John Eric Erichsen, On Railway and Other Injuries of the Nervous System (Henry C. Lea, 1867), 18.
impaired digestion and always had a pulse above ninety-six. Because of memory problems he would stop talking mid-sentence, and would often forget what he was talking about. His thoughts were confused and his attention on any subject was limited to a few minutes duration. He could only read for a few minutes without the letters blurring, he often misspelled words when writing, had horrible dreams, and often awoke frightened and confused. Another common complaint was feeling habitually hot and flushed with an accompanying dull, confused sensation. Loud and sudden noises distressed him a great deal, and he could not bear the noises of his own children at play. He often saw stars, lines, or other such images in his field of vision, and ordinary levels of daylight were distressing to him. He would sit habitually in a dark room without any artificial light sources, knitting and depressing his brows. He complained of smelling bad odors that others could not, and he felt pins and needles in his arm or leg. He had weakness in his legs and could not easily move about or flex his back. Erichsen’s diagnosis was that the patient suffered concussion of the spine with secondary inflammation being present in the meninges (membranes) of the spinal cord as well as “irritability of the brain and its membranes”. In 1866 the patient sued the railway company and was awarded £3,500, which was no small amount in that day.

Although we do not know whether this particular patient improved, many of the other patients did seem to gain some relief from their symptoms after receiving financial compensation through legal action. With a great deal of money and lawsuits at stake, Erichsen became a controversial figure. Caplan demonstrates the great disdain with which many railway surgeons and other physicians viewed Erichsen’s ideas, which continued across a number of subsequent publications. Considering how the concepts of “spinal irritation” and “concussion of the spine” had been put to use legally near the end of the century, it is easy to see that there were three obvious interpretations of patients like the one described in Case Eleven above. First, defenders of Erichsen continued to champion a somatic model of such symptoms on the basis of either an unseen or functional lesion. Second, there were detractors who believed that Erichsen had done a great disservice by legitimating those malingerers who were out for financial gain. Third, there were those who began to consider the possibility that the traumatic experience of being in a railway accident somehow affected the psychical/mental state of the patient, leading to physical symptoms

166 Erichsen, 59–61.
167 Erichsen, 61.
168 Caplan, Mind Games, 2–36.
that had no physical lesion at all. These three positions were fought out in the following years, and the developments that arose from those fights have been dealt with elsewhere.\textsuperscript{169} For our purposes, it is worth looking at Erichsen’s retrospective thoughts on the topic before concluding this section.

John Eric Erichsen, though a minor figure in the historical situation summarized thus far, influenced many people during the course of a long career, passing away at the age of seventy-eight in 1896.\textsuperscript{170} Two years before his death, Erichsen wrote an editorial to the \textit{Texas Sanitarian} reflecting on the categories of illness that he had popularized in the 1860s. He wrote:

> Nearly thirty years have passed since I first brought the subject of railway and other injuries of the nervous system to the notice of the profession. At that time, the pathology of the nervous system and injuries was very imperfectly understood, and even the nomenclature had not been invented. “Neurosis” and “neurasthenia” even, were unknown terms, and what I then, for want of a better name, called “concussion of the spine”, is now universally recognized and described under the more modern appellation of “traumatic neurasthenia”. The morbid states are the same, and the symptoms identical: but the name has been changed, and the modern designation is probably more in accordance with modern views than was the older one. In all my writings on this subject, I have pointed out that symptoms arising from railway shocks are identical with those that occur from other and more ordinary accidents of civil life, and that these symptoms so occurring had been described by surgeons many years before railways were dreamt of, and fully a century before I had written a line on the subject.\textsuperscript{171}

Of course, we have already seen that the term “neurosis” had been in use for some time when Erichsen wrote his first major work in 1866, but its decreased usage in Britain probably accounts for why Erichsen claimed not to have known the term. Neurasthenia, on the other hand, really did not appear on the medical scene in full force until after Erichsen had formulated his notion of railway spine. Although the term surfaced occasionally without much fanfare, the substantive debut of neurasthenia as a clinical concept occurred in 1869.

\textsuperscript{170} George Edgeworth Fenwick, Thomas George Roddick, and George Ross, \textit{The Montreal Medical Journal} (Gazette Printing Company, 1896), 438.
2.3 Nerve Discourse from 1869 into the Twentieth Century: George Beard and Neurasthenia

The choice to place 1869 as a dividing line in the historical discussion thus far is not entirely arbitrary, but it is biased. We know that neurasthenia as a clinical concept can be found in the written record dating back much earlier in the century. Gosling credits an Italian physician for its use in 1808\textsuperscript{172} and Pinero tells us that the term appeared in a few authors influenced by German Romantic medicine from the early 1830s.\textsuperscript{173} In choosing 1869, I am following the convention of crediting George Beard with the first systematic presentation and public advocacy for the wide-scale adoption of neurasthenia as a diagnostic entity. It is true, however, that even in the year 1869 (or perhaps at the end of the previous year) another physician had already attempted to bring the term to professional attention. “Observations on a Form of Nervous Prostration (Neurasthenia) Culminating in Insanity” was published in the 1868–1869 edition of the \textit{American Journal of Insanity} but it seems to have failed to bring much attention to its author, Edwin Holmes Van Deusen, despite the fact that his description of neurasthenia’s various situational causes, its symptoms, and physicalist models of explanation (e.g., nerve force, nerve power, etc.) are almost indistinguishable from those given by Beard. Schuster is one of the few authors who attempts to explain why Van Deusen failed to attract much interest, while Beard’s name became synonymous with the disorder.\textsuperscript{174} Schuster suggests that “alienists”, like Van Deusen, who worked in rural asylums for the overtly insane were more marginalized professionally compared to more urban, chic neurologists like Beard. Whatever the reasons, Beard succeeded in the promotion of his less-than-novel category.

2.3.1 Beard’s Debut Article

The April 29, 1869 edition of \textit{The Boston Medical and Surgical Journal} appears to be Beard’s first effort at introducing his ideas about nervous exhaustion to his peers. The journal article is based on a lecture given at the University of New York. In that lecture, Beard made clear that when he “refer[s] to neurasthenia, or exhaustion of the nervous system” he meant it as a “morbid condition or state” that he believed had been long understood, but that “the special name

\textsuperscript{173} Pinero, \textit{Historical Origins of the Concept of Neurosis}, 73.
neurasthenia” was only then being presented to the profession for the first time. After describing the Greek language etymology for his clinical term of choice, Beard continued his short lecture for the length of five or six pages. It is worth taking a moment to highlight three interrelated features of this debut article.

First, as the term “neurasthenia” etymologically signifies, “want of strength in the nerve” (p. 217) can be viewed analogously with anemia. “Anemia is to the vascular system what neurasthenia is to the nervous. The one means want of blood; the other, want of nervous force” (p. 217). Beard believed that both diseases could be caused by chronic or acute disease states. “Thus, neurasthenia may be the effect of wasting fevers, exhausting wounds, parturition, protracted confinement, dyspepsia, phthisis (consumption), morbus brightii (renal disease), and so forth” (p. 217). Continuing his analogy with anemia, Beard suggested that “constitutional tonics” (p. 218) were the best form of treatment for both diseases. With respect to anemia, tonics were given in order to affect the blood; in neurasthenia, tonics were given in order to affect the nervous system.

Second, one of the most interesting aspects of Beard’s analogy is the claim that “both anemia and neurasthenia are most frequently met with in civilized, intellectual communities . . . [T]hey are part of the compensation for our progress and refinement” (p. 217). Recalling Cheyne and other figures above, we see that Beard also made use of the “disease of civilization” theme, and this turned out to be a major feature of his delineation of neurasthenia in other works. In subsequent pages, I suggest that this theme plays no small part in the rise of neurasthenia in East Asia.

Third, Beard argued that neurasthenia resulted from slight, undetectable, physio-chemical changes in the central nervous system (CNS). He even went so far as to testify to his conviction that, in the future, microscopic and chemical examination of deceased neurasthenic patients at autopsy would confirm such CNS changes. Consistent with this physicalist notion of neurasthenia’s pathophysiology, Beard suggested that the condition could give rise to “dyspepsia, headaches, paralysis, insomnia, anaesthesia, neuralgia, rheumatic gout, spermatorrhoea” in the

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176 In the following discussion of Beard’s debut article, quotations will be referenced by a page number in parenthesis. When referencing his Practical Treatise, a note will indicate the change to that text.
177 The involuntary loss of semen is an ambiguous concept that ranges from involuntary ejaculation to the loss that occurs outside of any sexual context. This subject is addressed briefly in the next chapter.
male, and menstrual irregularities in the female” (p. 217). Interestingly, it is not a contradiction for Beard to state that neurasthenia could both result from and give rise to “dyspepsia” (p. 217, 218), for example. The reason for this is that the nervous system affects all others, and “neurasthenia may result from any causes that exhaust the nervous system” (p. 218). Although there is no indication that etiology is limited only to those hereditarily disposed, he did indicate that “hereditary descent terribly predisposes to neurasthenia” (p. 218). For those who may or may not be predisposed, there were still “exciting causes”, among which were “pressure of bereavement, business and family cares, parturition and abortion, sexual excesses, the abuse of stimulants and narcotics, and civilized starvation, such as is sometimes observed even among the wealthy order of society, and sudden retirement from business” (p. 218). Consistent with his overall view of the nervous system, it is reasonable that this list of exciting causes, and those in future works, should include both physical agents (e.g., narcotics) and those that might be considered psychological in nature (e.g., bereavement, family cares, etc.).

Beard’s second claim regarding the role of civilization in neurasthenia’s etiology would not have come as a surprise to contemporaneous readers. In the same year as Beard’s debut article, the American poet and doctor Silas Weir Mitchell published in Lippincott’s Magazine describing his views on the effect of modern work and its requirements on the intellectual capacities. In 1871 he enlarged his tract and published again in Lippincott’s under the title “Wear and Tear, or Hints for the Overworked”. In that volume, Mitchell expanded on the now-familiar notion that the intellectual classes were susceptible to a particular type of ailment, which was the direct result of their excessive use of mental faculties. Mitchell did not refer to neurasthenia by name, however, which lends some credence to the idea that the category came to prominence only after Beard. With Mitchell, the target audience was the non-specialist, and terms like “brain-fatigue” were common. Beard’s second major publication likely benefitted from Mitchell’s little tract, and Beard expanded his earlier views in 1880 with the publication of A Practical Treatise on Nervous Exhaustion (Neurasthenia), Its Symptoms, Nature, Sequences, Treatment, in which he delineated, in much greater detail, what he believed to be the scientific relevance of neurasthenia as well as the various reasons why the disease went undiagnosed and unclassified for so long. A detailed
analysis of Beard’s maturing conceptualization of neurasthenia is unnecessary for present purposes, but there are a number of important features that should be mentioned as they are important indicators of how the category was likely understood at the turn of the twentieth century.

Figure 3: Cover of Beard’s *Practical Treatise*

2.3.2 Neurasthenia Overlooked Historically

In posing the question, “why is it that this important field of science has been so little studied?” Beard offers four explanations.\(^{180}\) First, the symptoms of the disorder were subjective, and unlike surgical, acute, or inflammatory diseases, the physician could not see or feel any evidence of pathology with their senses or instrumentation; the physician must rely on a patient’s report of symptoms. Second, the nature of the disease could only be uncovered by the process of reasoning applied to the encounters across a large population of patients. Third, investigations of disease and various disorders had historically relied on research material drawn from hospitals, dispensaries and other institutions of charity; physicians studying in such a setting would fail to encounter a significant number of neurasthenic cases as the disorder was not as commonly found among the abjectly poor. Last, physicians had been overly dependent on European textbooks from countries like England and France, where neurasthenia occurred to a much lesser extent than in

\(^{180}\) Ibid., 4–10. The following discussion of Beard’s ontology and treatment for neurasthenia will include pagination in parenthesis from his *Practical treatise*. 

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the United States; neurasthenia was an American disease and had not been understood among the medical authorities of Europe. This latter point was not a denial of the existence of nervous diseases generally among European populations; rather, Beard believed that the specific disorder of neurasthenia was the result of American progress in all its facets, including her unique climate.

2.3.3 Ontology of Neurasthenia

An ontology of neurasthenia was already nascent in Beard’s understanding of its neglect by science, which facilitates a corresponding threefold description.

First, the disorder was not to be confused with organic or structural disease. On numerous occasions Beard explicitly stated that the disease was functional, not organic, and he made himself clear as follows:

Practically, we apply the term structural, or organic, to those diseases where the pathology, whatever it may be, can be brought under the direct observation of the aided or unaided senses. Functional diseases, on the other hand, are those where the pathology, whatever it may be, cannot be brought under the observation of even the best aided senses. What the microscope can see, we call structural—what the microscope cannot see, we call functional. In functional nervous disease, the pathology is negative—a deficiency in quantity or quality of the normal constituents of the nerve substance. In organic or structural nervous disease the pathology is positive—an addition of abnormal substances to the nerves. We can more easily supply what is wanting in the nutrition of the nerves than remove what is organized on the nerve as a foreign substance (p. 114–115).

The obvious implication, which he later stated outright, was that functional nervous diseases were more amenable to treatment. One should not forget, however, that Beard had made it very clear in his 1869 article that he believed science would one day be able to visualize a physiological, organic change in neurasthenics at autopsy, a possibility that would cause a shift in its categorization from functional to structural.

Despite its functional status at the time, Beard believed that neurasthenia’s pathological basis could be characterized, and this he did by describing it as an impoverishment of nervous force, a waste of nerve-tissue in excess of repair, which led to physical and mental feebleness and instability of nerve action (p. 115). In a sense, the nervousness of neurasthenia was a manifestation of “nervousness” or the failed function of nerves as a result of their excessive use without proper repair (p. 115). Hence, the various symptoms of neurasthenia resulted from reflex irritations
throughout the body secondary to deficiency of nerve force. Beard offered fifty-two major symptoms of the disease, and they make up the second chapter of his *Practical Treatise*. Because authoritative reference works in psychiatry merely state the number, rather than content, of Beard’s tally of symptoms, I have itemized the symptoms here despite the tedium.\(^{181}\) They are worth noting in order to demonstrate their vague and ubiquitous nature, which was later to contribute to the growing skepticism regarding neurasthenia as a meaningful category. They are as follows:

1) Tenderness of scalp: accompanied with heat and burning of the skin. Tenderness also occurs over the eyebrow, temple, or nape of the neck and can be brought on by emotional disturbance (p. 15).

2) Dilated pupils: temporary inequality of the pupils or sluggishness in dilation or contraction is a sign of neurasthenia or, at least, nervous irritability (p. 16).

3) Sick headache and various forms of head pain: this is a way for nervousness to manifest itself, and is commonest between ages of fifty and fifteen (p. 17).

4) Pain, pressure, and heaviness: particularly in the back of the head. Lightness of the head is also a common complaint (p. 17).

5) Changes in the expression of the eye: this includes protrusion of the eye, attributed to the sympathetic nervous system. Changes in the whites of the eyes (sclera) are also common (p. 18).

6) Congestion of the conjunctiva: during severe bouts of neurasthenic irritation, the eyes show heavy bags and appear as though the patient had been drinking heavily (p. 18).

7) Disturbances of the nerves of special sense: for example, neurasthenic asthenopia is a disturbance of the eye leading to difficulty with vision accompanied by headache, especially upon reading. No observable impairments can be found with ophthalmoscope or other instrumentation (p. 19).

8) Muscae Volitantes: floating specks within the eye’s field of vision (p. 20).

9) Noises in the ears: sudden explosive sounds or pulsations; tinnitus (ringing). These are more common upon exercise or exertion, but without physical cause detectable (p. 21).

10) Atonic voice: softness or faintness of voice (p. 22).

11) Deficient mental control: inability to concentrate on any task. The mind wanders, and is seen in cases of reading a paper several times without knowing what was read (p. 23).

12) Mental irritability: of diagnostic validity when the irritability is inconsonant with the normal temperament of the patient (p. 24).

13) Hopelessness: patients feel despair about life without any seeming objective cause, and are often challenged or ridiculed by family or friends for it (p. 25).

14) Morbid fears: these make up any number of bizarre phobias from fears of particular places, crowds, illness, disease, contamination, lightening, etc. (p. 26–42).

15) Frequent blushing: this can be brought on without any known cause to the patient or in the context of a thought, etc. It occurs in both sexes (p. 42–43).

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16) Insomnia: this takes numerous forms from inability to initiate sleep to the inability to maintain sleep. The mind is painfully active, and patients awake feeling very tired (p. 45–46).
17) Drowsiness (p. 45–46).
18) Tenderness of the teeth and gums (p. 46).
19) Nervous dyspepsia: this is often the first noticeable symptom; it is also commonly accompanied with flatulence. Unlike cases caused by gastric pathology, nervous dyspepsia can be treated with sedatives (p. 48).
20) Deficient thirst and capacity to assimilate fluid: patients are able to do with less fluid intake than normal. In this respect, Beard wrote that Europeans use more liquid nourishment as they are far less nervous than Americans (p. 49).
21) Desire for stimulants and narcotics: abuse of certain stimulants or the sudden inability to continue their normal use (p. 49–50).
22) Abnormalities of secretion: excessive moisture in the eyes. The opposite is also noted, with hair becoming excessively dry (p. 50).
23) Abnormal dryness of skin, joints, and mucous membranes (p. 50).
24) Sweating of hands and feet, with redness (p. 51).
25) Tenderness of the spine and of the whole body (p. 53).
26) Coccygodynia: tenderness of coccyx (tailbone), made worse when sitting (p. 54).
27) Peculiarities of pain in the back: tenderness or pain in the back, hips or loins which is transient and may suddenly disappear (p. 54–55).
28) Heaviness of the loins and limbs: one of the most frequent complaints is heaviness and aching in the limbs or whole body (p. 55–56).
29) Shooting pains simulating ataxia: shooting pains in the limbs (p. 56).
30) Podalgia: pain in the feet including numbness (p. 56–57).
31) Tremulous and variable pulse and palpitation of the heart (irritable heart): patients often show concern regarding heart disease, but no pathology can be found (p. 57–58).
32) Local spasms of muscles (tremors): spasm or twitching of the muscles are periodic and often annoying to the patient (p. 58).
33) Dysphagia (difficulty in swallowing): symptoms are sporadic without any objective cause being ascertained (p. 59).
34) Convulsive movements, especially on going to sleep: at the moment of falling into a sleep, a convulsive or spasmodic movement occurs suddenly bringing the patient back to wakefulness with a feeling of panic (p. 59).
35) Special idiosyncrasies in regard to food, medicine, or external irritants: sensitivities that were not present prior to neurasthenic state (p. 60).
36) Sensitivity to changes in weather: these include pain in the joints as well as emotional disturbance upon change in weather conditions (p. 62–63).
37) Localized peripheral numbness and hyperesthesia (p. 63–65).
38) A feeling of profound exhaustion unaccompanied by positive pain (p. 66).
39) Ticklishness: increases more than normal and becomes a severe annoyance (p. 67).
40) Vague pains and neuralgia (p. 67).
41) General or local itching (pruritus): itching of the scalp after intellectual exertion is one example. Other locations range from the face to the axilla (armpits) (p. 67–68).
42) General and local chills and flashes of heat (p. 68).
43) Cold feet and hands (p. 68).
44) Nervous chills (p. 69).
45) Sudden giving way of general or special functions: for example, sudden loss of strength leading to collapse while walking, etc. (p. 69).
46) Temporary paralysis: paralysis of a limb without any evidence of structural disease (p. 69).
47) Diseases of men: involuntary emissions, partial or complete impotence, irritability of the prostatic urethra (p. 70).
48) Diseases of women: irritability of ovaries or uterus (p. 71).
49) Oxalates, urates, phosphates and spermatozoa in the urine (p. 71–72).\textsuperscript{182}
50) Excessive gaping and yawning (p. 73).
51) Appearance of youth: the age of patients, despite their numerous complaints and symptoms, is always underestimated (p. 73).
52) Rapid decay and irregularities of the teeth (p. 74.).

The second aspect of Beard’s ontology of neurasthenia is that the particular symptoms themselves are not informative in the context of a single patient. It should be obvious that the physician needs to understand symptoms in the context of a patient population rather than an individual, but Beard’s meaning in this instance was to point out that neurasthenia was characterized by two unique subtleties; it mimicked organic diseases, and symptoms might manifest in an opposing way from patient to patient. For example, items 22 and 23 are seemingly exclusive, but patients might present with either excessive or deficient skin secretions; nevertheless, the physician was expected to deduce the malfunctioning nervous system as the causative agent in both cases even though the dysfunction was in opposite directions.

Third, Beard took great pains to show that neurasthenia was an ailment of those persons in modern, civilized society who were more likely to be of the intellectual classes. In other words, the patients filling the wards of poverty or charity hospitals were less likely to develop the disease as they were unlikely to tax their nervous system through the excesses of brain work. This line of thinking contributed to the accounting analogy of neurasthenia that became common after Beard’s death in 1883. For instance, in an 1887 monograph on \textit{Nerve Waste}, H.C. Sawyer drew on the banking analogy to describe the depletion of nerve force. He wrote that “the stock-board and the street are notorious fields of shattered nerves and softened brains, and every year the excitement of political campaigns makes \textit{overdrafts} upon the vitality of thousands . . . [The neurotic diathesis]

\textsuperscript{182} Beard does not discuss this quantitatively, making serious consideration of their comparison to normal impossible.
becomes established . . . as a result of the nervous strain and *overdraft* of civilized life; city Americans of the second and third generation are apt to be more or less neurotic".183

Last, as has been hinted at or stated explicitly already, Beard believed that the civilizational cause of neurasthenia was more readily present in America than in other nations. In addition to being a problem of the upper classes, it was particularly an American malady, in much the same fashion that Cheyne once argued that certain nervous ailments were best categorized as the English malady.

### 2.3.4 Treatment of Neurasthenia

The last chapter of Beard’s *Practical Treatise* is labeled “Treatment and Hygiene of Nervous Exhaustion”, and in those remaining sixty pages he discussed numerous aspects of health management aimed at both overcoming neurasthenia and avoiding its onset. Rather than list all the therapies that Beard discussed, I briefly summarize their use following a three-fold division: internal medications, mental therapeutics, and external therapeutics.

The supposed nature of neurasthenia required that its treatment follow specific principles. Beard believed that the physician should treat the local manifestations of the illness in whatever form they appeared, especially since the disease was not experienced in the same way among patients. Each case was to be handled as specific situations arose. Such being the case, the available internal medications were numerous and were considered with respect to substances positively to be prescribed as well as negatively to be withheld. For example, he made wide use of Bromide salts as well as phosphate compounds (p. 153–156), but suggested that certain chemicals, like caffeine, might have idiosyncratic effects and should be monitored accordingly. Laxatives were employed in order to provide a counter-irritation to the systemic irritation caused by the dysfunctional nerves (p. 168), and given the understanding and accepted practice of his day, Beard did not shy away from things like arsenic and strychnine. These, along with numerous other internal treatments, were often used concurrently and in combination with other therapeutic methods. In fact, there were myriads of tonics and patent medicines that grew out of the popularization of the diagnosis, the study of which deserves its own monograph. Suffice it to say that vast quantities of money were spent advertising pharmaceuticals that claimed to cure nervous  

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ailments generally and neurasthenia in particular. Among the most popular and controversial were those of Miles publishing company, which by 1891 had already put out a thirty-four page booklet on nervous disorders and their patent medicine treatments.  

“Antineurasthin” was another popular medicine, and its print ads could be found in magazines around the world, and for the discovery of which the pope’s physician offered his congratulations.

Figure 4: Full print discussion of Antineurasthin from 1909

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184 Dr. Miles Medical Company and Charles Franklin Miles, New and Startling Facts for Those Afflicted with Nervous Diseases: An Illustrated Treatise on Sick and Nervous Headache, Nervousness, Convulsions, Neuralgia, Apoplexy, Paralysis, Sleeplessness, Nervous Prostration, Sexual Weakness, Epilepsy, Dyspepsia, Etc (Dr. Miles Medical Company, 1891).

185 “The Englishman,” 1908.
Figure 5: Dr. Miles Nervine tonic was one of the most prolifically advertised patent medicines. It appeared twenty different times in the religious weekly magazine *The Interior* in the year 1899.186

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Figure 6: Article from American gazette, *Country Life*. The pope’s physician congratulates the discoverer of “antineurasthin”, the supposed cure for neurasthenia.187

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186 *The Interior* (Western Presbyterian Publishing Company, 1899), 1602.
187 *Country Life*, 1907, xcv.
Figure 7: A sedative advertised as a remedy for neurasthenia in *Pharmaceutical Journal*, published in London.\textsuperscript{188} This compound looks structurally like a sedative, but it is not in pharmacological use today.

*THE AMERICAN PHYSICIAN.*

**Nerve and Tissue Building**

The nervous system, most important of all, needs the closest attention in disease, and often receives the least. Many intractable and vitality-destroying diseases arise originally and solely from a disordered nervous system.

**C O L A S A Y A**

Coca-Cola-Calisaya Tonic

is pre-eminently the most successful nerve tonic and tissue builder. It restores the Nerve Balance so necessarily important in alimentary and nervous disorders—effectually removing Dyspepsia and other digestive derangements, Neurasthenia, Anemia, Sleeplessness, and Depression. Prescribe COLASAYA during convalescence from any wasting disease, and after physical or mental overexertion, and observe the prompt and brilliant results.

A palatable combination of the fresh extracts of Krey- thros, Coca, Kola nut, Calisaya Bark, and the Phosphates in superb old Sherry.

In original pint bottles, \textdagger 75c. One dozen bottles, \textdagger 85.00.

Samples free on receipt of \textdagger 25c. for mailing expenses.

This restorative was formerly called Coca-Cola-Calisaya Tonic, a name unwieldy to use and often leading to confusion with other preparations. The word COLASAYA has now been adopted.

ZWARTS PHARMACY CO., Fourth and Locust Streets, ST. LOUIS

Figure 8: Originally patented as a “Nerve Tonic”, even Coca Cola was advertised as a treatment for neurasthenia.\textsuperscript{189}

\textsuperscript{188} *Pharmaceutical Journal: A Weekly Record of Pharmacy and Allied Sciences* (J. Churchill, 1908), 449.

Beard was firm in his belief that mental therapeutics, though helpful, should never be the exclusive mode of treatment, and he made an effort to explain that, even though disease conditions might arise as a result of disturbed emotions or other aspects of the patient’s thought life, the physical pathologies that ensued were real nevertheless. Though they arose from the imagination, they were not imaginary, and they could not be spoken or thought away any more than could typhoid fever (p. 145). Beard’s physicalist position may have influenced his opinion of Charcot, which seems very ambiguous. On the one hand, he claimed that Charcot’s public exhibitions proved nothing about the nature of functional diseases, but his own personal communications with Charcot led him to believe that Charcot was at least making some headway into the physiology of hysteria and neurasthenia. Despite Beard’s view, mental therapies became the major treatment

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190 The New England Journal of Medicine (Massachusetts Medical Society, 1890), 6.
191 I have intentionally left Charcot out of the discussion on nervous disease. The literature on his work and thought is plenteous, but seems of little help with respect to my aims in this chapter. I believe that the charisma and fame of Charcot are an impediment to our understanding; great controversy flowed around his practice as it does around his work even today. For a discussion of Charcot, see Micale, Approaching Hysteria: Disease and Its Interpretations; Micale, “On the ‘Disappearance’ of Hysteria. A Study in the Clinical Deconstruction of a Diagnosis.” Also, see Chapter 7 of Shorter’s From Paralysis to Fatigue.
of neurasthenia in the twentieth century. Subsequently, the rise in psychotherapy in the USA, which predates Freudian theories, has been directly attributed to the medical community’s attempts to address the condition Beard popularized.\textsuperscript{192}

The preferred methods of treatment fall under the category of external therapeutics. Among these were hydro-therapies (water pressure on the outside of the body), Turkish and Russian baths, variation of hot and cold wraps, inducing small blisters on the skin of the back, magnets, metal therapies, and many others. Beard’s favored method, however, was the use of therapeutic electricity, which had already been written about widely by the time of his debut article. For example, Channing’s \textit{Notes on the Medical Applications of Electricity} was already in its third edition by 1852, and Beard had himself co-authored a text on the subject in 1881.\textsuperscript{193} Probably because electric therapies had been considered for some time, there were already a variety of home-therapy products available in the market. Regarding these, he had nothing good to say; rather he declared that “the galvanic belts, so much advertised, are of no value in nervous exhaustion”. Nevertheless, such products continued to sell after his death, as can be seen in the 1902 Sears and Roebuck catalogue advertisements.

Beard advocated a number of treatment methods using the application of electric current over parts of the body surface. Most of the machines that he described in his text were similar in structure and function, consisting of a battery with electrodes held by the physician and placed over the point of interest. The desire to manipulate nervous force with electricity and a variety of other therapies continued well into the twentieth century, until physicians grew suspicious of the conceptual model of neurasthenia and nervousness advocated by Beard and others. The question began to arise as to whether the experiences given the label “neurasthenia” really constituted a discreet entity.

\textsuperscript{192} Caplan, \textit{Mind Games}.

\textsuperscript{193} William F. Channing, \textit{Notes on the Medical Application of Electricity}, Book, Whole (Daniel Davis, Jr. and Joseph M. Wightman, 1849); George Miller Beard and Alphonse David Rockwell, \textit{A Practical Treatise on the Medical and Surgical Uses of Electricity: Including: Localized and General Faradization; Localized and Central Galvanization; Franklinization Electrolysis and Galvanocautery} (W. Wood & Co., 1881).
Figure 10: 1902 Sears and Roebuck advertisement for electric belt. Beard described the uses for the belt as chronic nervous disease and weakness, but does not accept its usefulness.
2.4 Views on Neurasthenia in the Twentieth Century

It is probably futile to search for the scientific discovery or major social actor that brought about the death of neurasthenia as a clinical concept in Euro-American medicine. In a manner similar to Micale’s description of hysteria’s “atomization” into multiple other categories, the twentieth century saw the dismantling of neurasthenia. The decline of neurasthenia has been dealt with by a number of scholars, but I will summarize the process by lumping the transformative forces into three categories: doubt about the usefulness of the category, changing paradigms in psychiatry and neurology, and new legal and institutional stances toward medicine and public health.

2.4.1 Doubts

Doubts about the usefulness of the category were present very early on in neurasthenia’s conceptual development. Papers read at professional meetings and articles carried in respected journals led to debate between famous physicians of the day. For example, as early as 1886, The Lancet published the observations of one of the physicians at a London hospital, Sir Andrew Clark. His essay forcefully argued that “the term neurasthenia is unscientific, inaccurate, and misleading; that the descriptions given of it do not include a clear, concise, or distinctive account of genuine nerve exhaustion, and do include a mob of incoherent symptoms borrowed from the most diverse disorders . . . [N]o rational principles of treatment are possible”. Clark went on to argue that the category added nothing positive to the notion of “nervous temperament” understood since the time of Cheyne, but instead created a catchall that served no purpose for medical knowledge. His essay led to a lengthy response in The British Medical Journal that same year by the professor of obstetric medicine at King’s college, William Playfair. Arguing from his own case accounts, Playfair defended the usefulness of the category and lamented its prior neglect.

In the United States, similar debates played out in American Journals despite the fact that the category was already in wide use. Drawing from the nosological research of Kraepelin in Germany, the New York Neurologist Charles Dana read a paper at the January meeting of the Boston Society of Neurology and Psychiatry in 1904. Later published in the Boston Medical and Surgical Journal, Dana’s paper levied some serious criticisms of the ease with which the diagnosis was being applied to a host of problems that might be better categorized in other ways. Specifically, he claimed that most of the patients diagnosed as neurasthenic were not actually suffering from nerve exhaustion, a somatic category that he believed still had value when applied only to those who experienced extreme fatigue secondary to physical exhaustion, toxicity of some kind, or disease in some part of the body locally. He pointed out that nearly all cases of diagnosed neurasthenia could more readily be attributed to the patient’s having taken a “hit” to their psyche; their underlying problem was nearly always one of a morbid mental state that resulted from the “mismanagement of their minds rather than their bodies”.

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198 Ibid., 342.
199 Ibid., 341.
consideration, Dana believed that at least fifty percent of neurasthenia cases could be removed from clinical diagnosis, a fact that he recognized as having such a huge cultural impact that he might be charged with disrespecting the “one great national malady”, especially if “America has been deleted of one of its most distinctive and precious pathological possessions”. In its place he proposed the term “phrenasthenia” (Greek: phrenos, mind; asthenia, weakness), but the term never caught on in clinical use. Nevertheless, the call to reconsider both the category and its terminology had not fallen entirely on deaf ears. Almost two years later (December 1905), at a meeting of the same society in Boston, the Rhode Island physician G. Alder Blumer delivered a talk on “The Coming of Psychasthenia”. While praising Dana for his call to improve the relationship between psychiatry and neurology, and their handling of patients labeled as neurasthenic, Blumer advocated for the adoption of “psychasthenia”. Without going into detail, suffice it to say that Blumer proposed the adoption of French psychiatrist Pierre Janet’s term psychasthenia over Dana’s phrenasthenia both because he thought the term, already in use, would be more readily embraced, and because he believed that Janet’s theories of psychoneuroses could better describe and distinguish the phenomena addressed by Blumer and Dana in their writings. Additionally, Blumer and others had a few years earlier already begun employing the diagnosis in state hospitals in the place of neurasthenia. In any case, psychasthenia entered clinical practice and would continue for a number of decades to coexist with and be used alongside neurasthenia, most likely in a synonymous manner.

2.4.2 Shifting Paradigms

The preceding, brief discussion regarding the debates surrounding neurasthenia’s usage blends the roles of doubt and shifting paradigms in the gradual decline of neurasthenia. A full discussion of the details of how theory changed in twentieth century psychiatry is beyond the scope of this work, but a few words should be mentioned about the ramifications of viewing neurasthenia as psychological in nature.

The shifting paradigms of twentieth century medicine made dealing with the problem of neurasthenia more difficult than could have been foreseen when it was originally proposed to be predominantly a physiological disease of nerve force. For instance, as early as 1895, Sigmund Freud wrote an essay titled “On the Grounds for Detaching a Particular Syndrome from

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200 Ibid., 341.
Neurasthenia under the Description ‘Anxiety Neurosis,’” in which he introduced ‘anxiety neurosis’ (Angstneurose) as a specific category. He began as follows: “It is difficult to make any statement of general validity about neurasthenia, so long as we use that name to cover all the things which Beard has included under it”. He went on to suggest that numerous neurotic disturbances could be separated out form “neurasthenia proper”, which was primarily a physiological problem. As Dana had done after him, Freud maintained that real neurasthenia existed, but that most cases so diagnosed were actually “pseudo-neurasthenias”.

While it is not necessary to enter into the details, it should be enough to point out that for Freud neurasthenia was an “actual neurosis” (neurosis here should be read as a “neuropathology”) that ought to be distinguished from the various psycho-neuroses that were the result of psychical conflict. As one might imagine, Freud claimed in his writing that “the specific aetiology of the neuroses has escaped Beard’s notice”, since Freud rejected the argument that the various nervous conditions arose etiologically from any of the factors discussed thus far in this chapter. For Freud, the various neuroses were etiologically related to sexuality and libido; interestingly, Freud also viewed neurasthenia as caused by the sex life, albeit for different reasons. Interrupting the sex act was one such culprit, but the main offense to the nervous constitution was masturbation, and Freud believed that “medical treatment . . . can have no other aim than to lead the neurasthenic, who has recovered his strength (by ceasing to masturbate) back to normal sexual intercourse”.

Most importantly for the current discussion, Freud contributed to the ongoing conversation regarding the overreach of the neurasthenic diagnosis, and incidentally, his influence would eventually dominate American psychiatry until the 1980s. Before Freud, as the title to Gosling’s study suggests, neurasthenia was on safe ground; but it should not be inferred from anything stated here that Freud was the major influence in neurasthenia’s decline. Such a conclusion would be oversimplified, even though Gosling suggests that the triumph of Freud’s views on the neuroses and psychoses was one of “three essential factors contributing to the downfall of the neurasthenic model”. It should be kept in mind that the hegemony of Freudian theory in American psychiatry

203 Ibid., 90.
204 Ibid., 148.
205 Ibid., 274.
did not eliminate neurasthenia from the DSM; the disorder appeared in both the first and second editions. Instead, it merely decreased its significance by first altering the clinical term to “psychophysiological nervous system reaction” in 1952, and then returning to “neurasthenic neurosis” in 1968.\textsuperscript{207} The term was finally removed from the DSM in the third edition of 1980.

In any case, shifting views on neurasthenia arose very early in the twentieth century and can be attributed both to the introduction of Freudian concepts as well as the failure to find the underlying organic lesion that Beard had hoped autopsies might eventually reveal. Caplan’s suggestion that American psychotherapy both predated Freud and arose as a response to the neurasthenic diagnosis, is a compelling argument in favor of the idea that neurasthenia gradually lost its status as a neuropathology and was increasingly seen as a psychopathology.\textsuperscript{208} This is all the more interesting considering that even Freud maintained the neuropathology view of neurasthenia; in other words, the Americans had already grown suspicious of the category long before theories of the unconscious and anxiety neuroses entered the scene.

2.4.3 New Legal and Institutional Stances

Among the influences that led to the decline of neurasthenia, we can point to changing policies within the American Medical Association as early as 1900. Schuster has called this the “crackdown on drug advertising”, and he argues that the AMA had some success in turning public opinion against the cure-all claims that were widespread in the print publications of the day.\textsuperscript{209} With changing policies regarding advertisements, companies were required to submit ingredients if they wanted to win print space for their products in medical journals. In addition, bodies like the Journal of the American Medical Association were eager to print chemical analytical studies done by independent researchers for the purposes of bringing to light questionable claims made by patent drug companies. For example, in 1952 JAMA published a critical piece titled “Antineurasthin: a new use for eggs and milk”, wherein the analytic makeup of that drug was shown to contain nothing more than egg yolks, milk, and potato starch. The method of analysis and the results were printed alongside a mocking criticism of the quack medicine.\textsuperscript{210} Eventually, 

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\textsuperscript{208} Caplan, Mind Games.
\textsuperscript{210} “JAMA: The Journal of the American Medical Association” 52 (1909): 1678.
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there were enough such articles that they were compiled into monograph format to be printed and then reprinted. By 1912, the second edition was extensive and was printed under the title, “Nostrums and Quackery: Articles on the Nostrum Evil and Quackery Reprinted, with Additions and Modifications, from The Journal of the American Medical Association”.

The professional efforts by the AMA to crack down on bogus medicines probably did have an impact on how the common person viewed the claims of pharmaceutical companies. Its efforts cannot be divorced from the fact that the United States passed the Pure Food and Drug Act of 1906. Nevertheless, Schuster probably overstates the impact to some extent, as the category stayed in the diagnostic manuals for several decades. Schuster downplays the role that neurasthenia played with respect to psychiatric and neurologic casualties of the first World War, arguing that British influence favored the term “shell-shock”. However, British authorities recognized the importance of neurasthenia in diagnosing mental trauma, as is evinced by professional publications such as H.C. Marr’s *Psychoses of the War: Including Neurasthenia and Shell Shock*. A full study of neurasthenia’s importance for military psychiatry has never been done however, and the closest such study seems to be one published by *Smithsonian*. Despite its use during World War I, by the close of World War II, neurasthenia seems to have fallen almost completely into disrepute.

2.5 Conclusion

In this chapter, I have undertaken the task of providing some background to neurasthenia and the discourses of nerves and nervousness, which were antecedent to the experiences of SJSR in East Asia. My overall aim has been to demonstrate the long life that such discourses have had, including some of the transitions that occurred in medical thought. Nervousness has been with us over such a terribly long span of time that it would not be feasible to contextualize its life through the Thirty-Years War in Europe (1618–1648), the American War of Independence (1775–1783),

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211 American Medical Association, *Nostrums and Quackery: Articles on the Nostrum Evil and Quackery Reprinted from the Journal of the American Medical Association* (Press of American medical Association, 1912). The term “nostrum” was another term for “quack medicine”, probably derived from the Latin *nostra*, “our”. Presumably the patent medicine owners referred to their medicines as “our” medicine or cure.

212 Enacted in 1906, the 59th Congress passed the legislation under the original title, “An Act for preventing the manufacture, sale, or transportation of adulterated or misbranded or poisonous or deleterious foods, drugs, medicines, and liquors, and for regulating traffic therein, and for other purposes”.


the American Civil War (1861–1865), World War I (1914–1918), and all the other wars and events that took place in between. The same difficulty can be found when thinking about neurasthenia specifically, even though its lifetime in “Western” countries only lasted a very short period, relatively speaking, approximately from 1869 to the 1940s.

The fact that neurasthenia was with us for a considerably short period does not in itself explain fully, however, why it has completely fallen out of the lexicon while nervousness has not. The social construction of neurasthenia in the West fit into a perfect niche of time and place, growing out of the already well-established discourse of nervous disease, but its cultural work soon came to an end. The discourses of nerves and nervous disease were the foundation that made neurasthenia possible as a discrete entity or category of diagnosis; their conceptualization created a space where neurasthenia could exist, and it has always been reasonable to view neurasthenia as an outgrowth or extension of what it means to suffer from nervousness or nerves. The question to consider at this point is how such a relation differs from the experience and conceptual development of neurasthenia as a category in East Asia, where there was no long history of nerve discourse to ground the newly introduced idea. In order more fully to address this issue, as well as to assess critically the models of neurasthenia attributed to Kleinman and colleagues in the fourth chapter, I begin in the next chapter to look at the Chinese experience of neurasthenia, starting with its introduction into East Asia at the turn of the twentieth century.
Chapter 3: Weak Nerves in China

“The ‘origin’ of the word is less meaningful than the process of its transformation and its taking root in another culture and renewing it”.


Having summarily addressed the long-standing discourses of “nerves” and “nervousness” in the European and North American context out of which neurasthenia arose as a conceptual and diagnostic category, I will now turn to the issue of such discourses as they take root in East Asia. Specifically, this chapter is about neurasthenia in the context of its arrival in China, having been first introduced to and making entry via Japan.

For many years it has been assumed that the concept and orthographic depiction of neurasthenia as *shenjing shuairuo* (神經衰弱)215 was a Japanese neologism, though the precise dating of its inception was long left a question for historical research. For example, when writing in 1986, Kleinman limited his discussion of this issue to the remark that “[n]eurasthenia had been introduced into Japan from German medicine”, citing as evidence work by T. Suzuki that was in press at the time and was published in 1989.216 Unfortunately, the only information that Suzuki’s paper later provided was the claim that “[t]he term Neurasthenia was introduced to Japan in the late nineteenth century”, after which he immediately turned to the transformation of the clinical category that occurred at the hands of famed Japanese psychiatrist, Morita Masatake217 (森田正馬), in the 1920s.218 After several decades of research, we now know only a little more than we did in the 1980s, and some of that clarification will be addressed in the pages that follow. It should be kept in mind that among the models of SJSR offered by Kleinman and Lee is the suggestion that SJSR really came to life under Mao as a consequence of the public suppression of affect. While

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215 Hereafter abbreviated as SJSR, as above, for the Chinese pronunciation of the kanji. When referring to shinkei suijyaku as it existed in Japan, I will also use SJSR with the expectation that the reader understands that the kanji and diagnostic category were the same lexically but not necessarily the same in all cultural aspects.


217 Morita’s given name, 正馬, is almost invariably written as “shoma” by those researchers whose primary research language is Chinese and who rely on Onyomi. Morita’s Japanese given name is correctly pronounced “Masatake”.

this is incorrect, it seems accurate to claim that SJSR took on new meanings in the post 1949 period, which is modestly to be touched upon in later chapters.

Presently, the material in this chapter is organized so as to make a particular argument about the status of neurasthenia in China prior to 1949. I will summarize some of what is now known about the origins of SJSR as it first appeared in Japan, relying on recent research that has uncovered some of, if not the, first references to the term in Japanese writing as well as some of the ways it was then understood. I believe that SJSR played very different roles in the modernization projects of China and Japan, the details of which should become clearer below. My argument is a variation of the sixth of Shapiro’s dominant explanations (status) cited in Chapter 1. Recall that Shapiro suggested that psychiatry and anthropology have produced the most serious analyses of SJSR, among which is the notion that the category conferred status or that the diagnostic label was fashionable, notions also at play in the American and European experiences of nervousness and neurasthenia as presented in Chapter 2. However, in this chapter, rather than refer to the analysis of SJSR with respect to the status or fashionableness for the individual person, I apply it to a nation and consider what the category has meant from that vantage point. To oversimplify: in the Japanese context, SJSR was a problem of Westernization; in China, it was a national accomplishment. I present this position in the following manner. First, I present some background to SJSR in Japan, including findings regarding the origins of the translation of SJSR into Chinese (Section 1). I then summarize recent research that argues that, in early twentieth-century Japan, SJSR was seen as a malady resulting from the deterioration of Japanese ways of life (Section 2). Third, I suggest that the atmosphere in China was ripe for a very different appreciation of SJSR; in particular, that SJSR could be seen as evidence of Chinese progress (Section 3). This section deals primarily with Lu Xun and one of his most renowned creations, Ah-Q, to point out how he could view neurasthenia as an indication of the progress of a people toward modernization. In Section 4, I offer further proof of the entrenchment of neurasthenia into the Chinese lexicon with examples from print publications of the day, both non-fiction and fiction. Finally, the chapter concludes with a summary of the importance of SJSR as a conceptual category in early twentieth-century China prior to 1949, the significance of which highlights what has been neglected in the mainstream models of neurasthenia so far prominent in cross-cultural and anthropological psychiatry. Models that I begin to describe in detail in the next chapter. A special focus is given in this last section to cultural performances of madness.
3.1 Brief Background of Neurasthenia’s Introduction to Japan

Bowers has documented the Meiji effort to modernize medicine by adopting German infrastructure as a national paradigm. The changes that took place in the Meiji and Taisho have been characterized as a major cultural transformation. In her work on the historical development of depression as a conceptual category in Japan, Kitanaka Junko has convincingly argued that this period witnessed an epistemic shift away from previous models of illness etiology toward a European discourse of the brain and nervous system as the site of pathology. She terms the era “The First Expansion” in her periodization of the expansion of psychiatry into everyday life in Japan. Not only were sorcery, magic, and shamanism outlawed, but in an effort to establish German Neuropsychiatry, even traditional medicine was repressed. Neuropsychiatry was officially made a department within Tokyo Imperial University in 1886; and according to Fujikawa Yu, by 1911 native Japanese held the position of “Chair of Psychiatry” in the medical faculty of the University of Tokyo, Kyoto University, and another medical university in Fukuoka. All had been trained in Japan before studying in Germany, Vienna, or Paris. Additionally, the “Japan Psychiatric Society” was founded in 1904 around the same time as the “Japan Society for Neurology and Psychiatry”. Throughout the Taisho period and leading up to World War II, psychiatrists became regular contributors to newspapers, magazines, and self-help manuals in an effort to educate the populace about the importance of the hygiene of nerves (on the establishment of Eisei generally, see Rogaski, Jannetta).

It is not surprising that the major focus of nerve hygiene in Japan was the epidemic rise in neurasthenia. This disorder had become a topic of prolific publication in America and Europe, and

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220 She lists these phases as follows: The First Expansion (1870s-1930s) Modernizing Japanese bodies from yojo to Eisei, The Second Expansion (1950s-1960s) Institutional expansion and anti-psychiatry movement, and Third Expansion (1980s-present) contemporary discourse.
221 Kitanaka, *Depression in Japan: Psychiatric Cures for a Society in Distress*, 40.
Susan Burns, “Contemplating Places: The Hospital as Modern Experience in Meiji Japan,” in *New Directions In The Study Of Meiji Japan* (Brill, 1997), 708.
its introduction into the medical sphere in Japan, and subsequently China, is universally attributed to the clinical description given of it by George Beard in 1869. Even Morita Masatake, the most famous Japanese psychiatrist associated with debates surrounding neurasthenia and its treatment in the 1910s and 1920s, attributed the clinical concept to Beard. Yet, the earliest uses of the Japanese kanji that were to designate the category of neurasthenia actually pre-date any use of the English term by Beard. How the term entered into the Japanese and Chinese linguistic and conceptual spheres, therefore, has proven less obvious than expected.

The translation of the term “nerve” (Chinese shenjing, Japanese shinkei) is generally considered to be the work of Sugita Genpaku in his Kaitai shinsho (解体新書), but prior to the official adoption of German medicine, the term seems to have remained obscure. One known exception is the efforts of Komori Genryo 小森玄良 (1781–1843) who attempted to relate the German term with the traditional concept of keiryaku (經絡), which, in the indigenous medical systems of China, are the meridians or channels through which Qi is believed to flow. It is less clear where “neurasthenia” finds its first kanji translation. Using a tertiary source, Kitanaka cited an early explanation of the causes of utsusho (鬱症); she cited Kaneko Junji (1965) who is supposed to be citing Komori Genryo. If this is an accurate citation, it probably predates all uses of the term in English.

The presumed standard citation for the earliest instance of SJSR appearing in Japanese-kanji usage is given by the Nihon kokugo daijiten. In its most recent publication, the earliest citation offered by the dictionary is that of Ogata Koan’s (緒方洪庵 1810–1863) 1842 translation from Christoph Wilhelm Friedrich Hufeland’s (1762–1836) Enchiridion medicum

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226 Masatake Morita, 神經衰弱と強迫観念の根治法: 森田療法を理解する必読の原典, 新版 (白揚社, 2008), 1.
227 Recall from the previous chapter that Van Deusen and others had used the term before Beard, but Beard was the first systematically to describe the category with rigor and multiple publications.
228 Shapiro, “Neurasthenia and the Assimilation of Nerves into China”; Kitanaka, Depression in Japan: Psychiatric Cures for a Society in Distress; 日大辞典刊行会, 第二版編集委員会, 国語辞典編集部, 日本国語大辞典, vol. 2 (小学館, 2000).
230 Kitanaka, Depression in Japan: Psychiatric Cures for a Society in Distress, 37. I have been unable to locate the sources she cited here.
231 日大辞典刊行会, 第二版編集委員会, 国語辞典編集部, 日本国語大辞典, vol. 2.
232 扶氏経験遺訓
The original German term *schwächung der nerven* (p. 262) is literally translated as 神經衰弱 (Japanese *shinkei suijyaku*, Chinese: *shenjing shuairuo*). Writing in a section on hypochondriasis and hysteria, Hufeland stated that these two illnesses were essentially the same disease except that hysteria was basically limited to women. Regarding the gender-neutral malady of nervous debility, however, he explained (p. 204):

The debility of nerves (schwächung der nerven), especially from excesses in venery and onanism in both sexes; immoderate exertion of the faculty of thinking, and also feeling, perpetual physical or moral sufferings as pains, sorrows, excessive corporeal exertion, continuous debilitating evacuations, especially of loss of blood by too frequent venesections, menstrua, hemorrhoids, chronic diarrhea (also hypercatarsis), gonorrhea, in the female sex (often as a secret cause) flour albus.

Interestingly, in this passage there is a familial relation to Beard’s clinical description of neurasthenia given thirty-two years later, further suggesting a historical continuity as outlined in the previous chapter. However, Koan’s use of the kanji predates Beard’s or Van Deusen’s coinage of the term by twenty-seven years.

Recently, research by a Japanese scholar has demonstrated that the *Nihon kokugo daijiten* is incorrect, with a new attribution being placed several years earlier. In 2003 Watarai Yoshi-ichi (度会 好一) published his study of the history of nervous disease in Japan’s Meiji period titled, *Meiji Seishin no Isetsu*. The first chapters point out that references to 神經衰弱 in the texts of the Rangaku scholars should not carry all the conceptual information that Beard later formulated for neurasthenia in his own phenomenology of the disease. In one subsection, Watarai chooses to make a distinction between “*shenkei suijyaku* and the *shinkei suijyaku*-disorder of American
There he cites the earliest known reference to the term so far, which he claims can be found in the 1822 work of Udagawa Shinsai (宇田川榛斎, 1769–1834) in his text titled Ensei iho meibutsoko (遠西医方名物考). With this reference, Watarai has further demonstrated that, as was the case with Ogata Koan, Udagawa’s use of kanji to translate Dutch texts was an early use of the neologism that would eventually come to describe the phenomenology of that specific disorder attributed to Beard.

3.2 A Deterioration of Japanese Ways of Life

The role that neurasthenia played in Japan’s modernization has been treated by scholars in different ways, depending, it appears, on the window of time and theoretical orientation though which the issue is analyzed. One typical example can be found in Sabine Frühstück’s handling of the topic with respect to the “building of a modern Japan”, found in an edited volume with the same title. In that article, she attempts to show that the discourse of neurasthenia was intimately tied to nationalistic efforts at providing an ideal for the type of masculinity necessary for Japan’s war efforts. Both among those being evaluated as military recruits and those who were selected to be military brass, it was necessary to recognize and remove the “lazy [or] effeminate” while ensuring that both classes of men were of strong nerves since “to suffer from neurasthenia would be very dangerous in the case of military leaders who work under a lot of pressure”. Within Frühstück’s theoretical and hermeneutic orientation, sexuality becomes the major locus of concern, a notion that is not without legitimacy. She points out that masturbation and homosexuality were among the causal explanations given for neurasthenia’s negative impact on the national supply of soldiers, but this is only one aspect of the narrative, which has some precedents even in the writings of Ogata Koan, Hufeland, Beard, and later theorists like Freud. To overemphasize the importance of sexuality is an obvious error, however, as can be seen by Frühstück’s recognition that, by the 1950s, writings on neurasthenia had once again focused on the stressors placed on over-burdened

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237 Watarai, 31: “神経衰弱とアメリカ生まれ神経衰弱症.”
238 His citation of the exact location of the term occurs on pages 31–32, and is footnoted on pages 262 and 263.
240 Fruehstueck, “Male Anxieties,” 43.
white-collar workers, completely independent of their sexual lives.241 A broader understanding of the condition, therefore, must consider neurasthenia as an exemplar of the negative consequences arising from Japan’s efforts to modernize and thereby avoid being counted among the colonized. It can be argued that those very efforts resulted in Japan’s colonization of itself with things foreign through a shift in cultural practices and norms of societal life.

In his extensive study of alternative treatments for neurasthenia in Japan from 1890–1945, psychiatrist and historian Wu Yu-Chuan has very convincingly argued that the disorder was a burden for Japanese people in a way substantially different from the experience of European and North American sufferers.242 Analyzing primary source material from the turn of the century, Wu successfully demonstrates that, by 1920, there were already a number of very popular and allegedly successful forms of treatment for neurasthenia in Japan, the treatment modalities of which were inseparable from specific theories of etiology. In other words, the therapeutic methods becoming broadly known owed their existence to etiological theories and models that explained how neurasthenia arose within the patient. Those treatments and causal theories highlight for us the cultural meanings that were attributed to neurasthenia from the vantage point of both professional and popular conceptualizations of the disease, at least until the height of the war effort.

Wu begins his study with the 1909 publication of Neurasthenia and Recovery by the former Tokyo Daily news managing editor, Ishikawa Hanzan. By comparing Ishikawa’s experience and treatment methods to those of numerous other authors of the day, Wu argues that not only were the three characteristic symptoms—(1) reverse upward flushing of blood (gyakuzou), (2) tension of the shoulders (katakori), and (3) coldness of the feet—quite common among those writing about neurasthenia at the turn of the century, but they also formed a constellation that was best described as a sense of “top-heaviness”.243 The congestion and tension in the upper body coincided with a feeling of weakness in the rest of the body, all of which demanded a physiological explanation. Ishikawa went so far as to claim that even the return to traditional garments like the tafusagi (褌) could be instrumental in reversing the effects of neurasthenia. Wu cites Ishikawa quoting a Navy captain, whose logic was as follows:

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241 Ibid., 39.
243 Ibid., 46.
Since *sarumata* and *fundoshi* became popular in Japan, the will power of Japanese men has considerably declined . . . The *tafusagi* can constantly locate the mind in the *tanden*. The knot tied over the principal part of the spine can repress the upward flushing of blood . . .

that I could remain so calm in the terrible battlefield of the Russo-Japanese war was all because of wearing the *tafusagi*. 244

Of course, to the modern reader this attribution made to the Japanese loincloth sounds like nonsense. However, the point is that there was such a belief, and as we will see later in this chapter (in a Chinese context), such beliefs have their impacts whether they are correct or not. In any case, Ishikawa believed that the predominant causal features of neurasthenia could be undone by a return to traditional methods of living forfeited in the rush to modernization. This theme is continued across the primary literature, and is evinced by the major therapeutic systems that were promulgated to combat the disease. Even though it is true that Japanese neurasthenics could attribute their strange physical sensations to the overworking of the brain, which was a necessary part of modern life, as Beard similarly claimed, it was not the newness or excessiveness of modern demands per se that caused the symptoms. One can easily image that people in any period of history could equally exhaust their brain-power or nerve-force (as the explanatory models put it) given enough strain and stimulation. What made neurasthenia a problem was that the traditional forms of life that naturally buffered against excessive demands had been undermined by adopting Western ways of living.

For example, Wu points out that Japanese scholars of industrial psychology like Ueno Youichi (1883–1957) undertook studies comparing Western and traditional Japanese sitting styles. Ueno described Western habits of sitting as bending/hanging at the waste, *koshiwokakeru* (腰を掛ける) and Japanese as *suwaru* (座る), thereby playing on the notions of stability carried in phrases like *suwarigayoi / suwarigawarui* (座りが好い / 座りが悪い). The excessive demands of modern work, when done in the posture of *koshiwokakeru*, led to the depletion of the central nervous system. The comparisons do not stop there, however. The adoption of numerous other standards such as Western-style calisthenics in public schools were seen as exercising the skeletal muscles while neglecting the belly and *tanden*, and the two “major neurasthenic symptoms [rushing of blood in the head and stiff shoulders] were consequences of the transformation of body

244 Ibid., 44.
position in modern life”. Famed bacteriologist, physician, and winner of the Japan Order of Merit, Futaki Kenzo (1873–1966) also attributed neurasthenia to changes in lifestyle, but his focus was on changes that led to compromised circulation. His books on abdominal breathing and his invention of the “abdominal pressure meter” were tools meant to reverse the weak diaphragm and strengthen the belly’s ability to control the movement of blood, all of which aided in meeting the demands placed on people by modern society.

Numerous other forms of abdominal breathing, *ki* (気) exercises, and quiet sitting can be found across a plethora of publications, but the common thread was reclamation of Japanese tradition. This raises the obvious question regarding the extent to which Japanese understandings of neurasthenia were the result of nationalistic efforts at ideology. Wu does not address this issue in any detail other than a brief section on tropical neurasthenia among Japanese in Taiwan. In that case, he shows the ideological use of claiming degeneration in those Japanese raised in the colony, insofar as they were separated from the mainland of Japan. However, that issue is not of particular importance presently. Whatever the role of imperialist ideology, it does not seem to detract from the major conclusion Wu draws:

Neurasthenia, without doubt, was a disease of modern civilization in Japan as it was in the West. But neurasthenic Japanese viewed modern civilization differently from patients in the West. For the Japanese, modern civilization was not wearing and upsetting because the lifestyle was fast paced and mentally stressful or because it was lavish, excessive and corrupt [as Beard had claimed]. Instead, it was mainly because it changed their lives extensively and substantially, particularly in terms of how they perceived, posited and took care of their bodies . . . Their neurasthenic bodies were not exhausted bodies that were created by the economic laws of energy saving and consumption. Neither were they degenerate bodies determined by the laws of heredity. They were ‘top-heavy’ bodies, both literally and figuratively.

In other words, therapies worked “not by undoing but by accommodating” the body to the strains imposed on it. The obvious implication is that, according to the major conceptualization of neurasthenia prevalent across the literature, Japan would have modernized without the problems of neurasthenia, had they simply modernized technologically while foregoing the variety of

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245 Ibid., 64.
246 Ibid., 125.
247 Ibid., 126.
changes in cultural practice that came with the embrace of Western methods. That is, the burdens of modernization that Beard pointed out as causes of neurasthenia would have been manageable if the Japanese had only maintained traditional customs and cultural ways of life. How that might be perceived is not of particular importance here, but it suffices to show that neurasthenia was conceptualized as a burden remediable by being more fully Japanese.

Before moving to the next section, some mention should be made of the ontological status of neurasthenia as it was viewed in Japan. Briefly, let us assume that the experience of neurasthenia in Japan was actually the result of a taxing modernity that only arose in the absence of certain modes of bodily comportment, the ideal forms of which were historically maintained by traditional lifestyles. It could then be concluded that neurasthenia was a functional disorder of the nervous system that naturally arose under the conditions of modern civilization, or something like it, but could have been avoided by the Japanese had they merely kept to certain practices throughout that very process of modernization. I take this position to be the predominant model of neurasthenia in Japan during the first several decades of the twentieth century. The ontological status would then be something like the fatigue of anemia (as Beard made analogy), which could have been avoided had the Japanese only maintained their traditional diet, as the analogy would have had it. As we will see throughout the pages to follow, the ontological status of neurasthenia is not so simple; but neither should it be dismissed as a fiction or as really being “x”, whatever “x” might be claimed to be. Additionally, I hope to continue problematizing “somatization” as an explanatory concept for neurasthenia.

3.3 China’s Modernization Project

The present section returns to a question raised in the first chapter via Hugh Shapiro, “How should we understand the popularity of neurasthenia in twentieth-century china?” While this question is also a variant of the main question of this dissertation as a whole, it is particularly relevant here as I hope to convince the reader that SJSR became popular in China in a manner specific to its own circumstances. In one sense, this seems obvious and trivial, but my point is to contrast the situation in China with the scenario framed in the discussion of Japan above. In order to do this, I will subdivide the present section into three parts. In Section 3.1, I begin with some

248 Shapiro, “Neurasthenia and the Assimilation of Nerves into China,” 2.
preliminary comments on the introduction of the term SJSR into the Chinese lexicon, a task that is probably impossible to undertake in any exhaustive sense, given the plethora of influences involved. In Section 3.2, I show how neurasthenia served for some Chinese as evidence of their modernization, focusing especially on Lu Xun (hereafter, LX) in Section 3.3. Finally, Section 3.4 delves more deeply into the character of Ah-Q in relation to the views on Chinese nerves of George Beard and Arthur Smith of Ah-Q’s creator himself, LX.

3.3.1 Neurasthenia Enters the Chinese lexicon.

In considering the earliest introduction of SJSR as a term and concept into Chinese society, there seems no clear path to follow as the process involved numerous inroads, ranging from materials in Japanese translation, the influence of foreign medical missionaries, Chinese students studying in Japan, and an international marketing network that advertised patent medicines claiming to heal a variety of ailments, including neurasthenia. Nevertheless, some diligent work has been done in this area. Of all attempts to trace the “assimilation of nerves into China”, by far the best efforts seem to be those undertaken by Hugh Shapiro, as already mentioned.249 His analysis follows the varied attempts at translating “nerve” into Chinese characters from the early sixteenth century Jesuit uses of jin (筋) to twentieth-century protestant missionary uses of naoqi jin (脳氣筋). Delineating what forces led shenjing to winning out over other options is still a work in progress. With respect to SJSR in particular, research has produced even less.

Despite the difficulty of sniffing out the introduction of SJSR into the worlds of Chinese linguistics and culture, no shortage of claims has been made regarding the matter. One of the more cautious claims was first made by Kleinman in 1986 when he stated that “it is not certain how the concept of neurasthenia entered China”.250 While he was right about this, he goes on to say that, given limited access, he could not find any mention of the term prior to the First World War. With the earliest reference to “neurasthenia” (English term) that he could find in the China Medical Journal appearing in 1923, he pointed out that in 1926 the missionary physician J.L. McCartney referred to “the Chinese as ‘nervous people’ given to ‘oriental nerves’ because of the great social


250 Kleinman, Social Origins of Distress and Disease: Depression, Neurasthenia, and Pain in Modern China, 24.
changes of the time”.\textsuperscript{251} Kleinman concluded that the “stage was set for the transfer of neurasthenia to a Chinese context”, which he presumably thinks took place around that time, partial evidence for which claim is reference to the earliest Chinese language article on SJSR he could find, published in 1930, a few years after McCartney.\textsuperscript{252} It seems that Kleinman understood that the actual introduction of SJSR into Chinese took place much earlier, but that the palatability of SJSR as a conceptual category had arrived with the 1920s. As we will see, this dating is also somewhat too late.

The idea that SJSR really came to the fore in the 1930s has been repeated by others in less cautious terms. A 1989 special edition of \textit{Culture Medicine and Psychiatry}, for example, contained the article “The Diagnosis and Phenomenology of Neurasthenia: A Shanghai Study”, which repeats the notion of SJSR popularized in cross-cultural psychiatry.\textsuperscript{253} Author and psychiatrist Zhang Mingyuan conducted research while he was working at the Shanghai Institute for Mental Health, where he had firsthand experience of SJSR’s predominance as a diagnostic category among Chinese psychiatrists in the final decades of the twentieth century. He concluded that neurasthenia was diagnosed in China in such a manner that it fell along a “disease spectrum ranging from mild personality disorder to simple sleep disorders”.\textsuperscript{254} Commenting on the fact that SJSR was the most frequently reported diagnosis among his colleagues in China, Zhang mused, “one may wonder whether it is due to a difference in the geographic distribution of mental disorders, or to variations in diagnostic concepts in different countries”.\textsuperscript{255} His own view seems to be that it is an admixture of both. Believing in 1989 that SJSR was growing in popularity, Zhang suggested some reasons for its wide acceptance similar to those addressed above in Chapter 2. Most importantly for my present purposes, he wrote that “it is believed that the term neurasthenia came to China in the early twentieth century and first appeared in a Chinese medical publication in the 1930s”.\textsuperscript{256} Specifically, he attributes the rise of SJSR to the turbulence of the 30s and 40s, fitting a needed role in diagnosis for physicians at that time. This historical claim has been oft repeated but is not factual.

\textsuperscript{251} Ibid., 25.
\textsuperscript{252} Ibid., 26–27.
\textsuperscript{254} Zhang, “The Diagnosis and Phenomenology of Neurasthenia a Shanghai Study,” 148.
\textsuperscript{255} Ibid., 148.
\textsuperscript{256} Ibid.
As Shapiro has pointed out, cultural psychiatry has produced the largest literature on SJSR, and as a result, its influence has extended into other academic disciplines. This influence can be seen, for example, in Raoul Birnbaum’s chapter on the conversion of the famous Buddhist master Hongyi in *Buddhism and the Modern World*.²⁵⁷ Hongyi’s (Li Shutong) self-diagnosis of SJSR played a pivotal role in his move to become a monk and leave his life in society. Most interestingly, Birnbaum has a great deal to say about SJSR in Hongyi’s life and all the efforts at self-cure that he undertook beginning in 1916. Despite this conversion in the 1910s and the explicit discussion of SJSR, Birnbaum goes on to claim “the term came to China in the early twentieth century and *first appeared in a Chinese medical publication in the 1930s*”. ²⁵⁸ He then references Zhang Mingyuan’s commentary regarding the popularity of SJSR in China. It is simply worth noting that it makes little sense that Hongyi would struggle with SJSR at the end of the first decade of the twentieth century if SJSR only appeared in the third or fourth.

Peng Hsiao-yen, at Academia Sinica, has given us a better picture of the difficulty in understanding the historical contingencies behind SJSR and its popularization in China. As I will return to her as well, it is worth noting that she takes SJSR back to the 1910s, including reference to several Japanese works in classical Chinese translation. She makes an effort to point out that, from 1894, Japanese texts already included the modifier *kan-nou* (官能) with neurasthenia (*kan-nou shinkei suijyaku*), in order to indicate it as a “functional” nervous disorder, as we saw in Chapter 2. She states:

> In China the term ‘神經衰弱’ appeared in the 1910s. The earliest title I can discover in the National Bibliographic Information Network of National Central Library in Taipei is Three Great Studies on Neurasthenia . . . published by Medical Bookstore in Shanghai in 1910. . . . This book is unavailable, but from the terms such as ‘官能症’ and ‘神經衰弱’ used to describe it in the library catalog, one can assume that it is based on Japanese sources.²⁵⁹

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Peng’s efforts are helpful in placing dates on some of the early influences that may have facilitated the cultural appropriation of SJSR. Still, the introduction of the idea into China took place even earlier, and it may be impossible to pin down any first instance of cultural transfer, including publication of a first textual reference. Publications of various materials and popular references to and discussions of the malady were taking place before the close of the first decade of the twentieth century, as we will see in Section 4 below, and we can be hopeful that future research will shed light on numerous sources unknown to us even today. Presently, however, we should turn to a consideration of how the cultural milieu in China made possible a unique appreciation of neurasthenia, even to the point of viewing it as evidence for national progress.

3.3.2 Evidence of China’s Modernization

In order to contrast the manner of neurasthenia’s reception into China\textsuperscript{260} with the situation in Japan, as outlined above, there are a number of non-trivial assumptions that must be admitted. For example, use of the term “reception” indicates a particular orientation to the movement of ideas, an orientation that views neurasthenia as having been received into Japan and China subsequent to its construction and development as an idea in the Euro-American context. As a concept and a lexical term, neurasthenia was translated from one space to another, any description of which carries with it theory-laden notions of “source” versus “target” language, host/guest relationships, or other similarly complicated manners of speaking.\textsuperscript{261} Nevertheless, while I do not believe that reception is a passive process, it is not my intention to argue for the fairness of the term “reception” or to defend any other theoretical framework. Therefore, I will move directly toward an attempt at describing the situation that gave rise to neurasthenia’s popularity in China, and I will borrow from whatever conceptual categories that may aid my description.

At the risk of appearing unoriginal, I find it necessary to frame this subject matter by starting at the same place Lydia Liu begins her work on Translingual Practice; that is, I begin with LX. His early representation of the typical Chinese person as backwards and in need of the healing potential of literature is not something that grew out of a vacuum, as Liu carefully demonstrates.

\textsuperscript{260} Use of the term “China” is also problematical, but only mildly so. Even though some of the relevant sources in this chapter refer to a “China” that existed before the establishment of the Republican government, I use the term China, as the topic has been fought out elsewhere.

\textsuperscript{261} Lydia He Liu, Translingual Practice: Literature, National Culture, and Translated Modernity—China, 1900–1937, (Stanford University Press, 1995), 27. Liu proposed “host language” and “guest language” in an effort not “to subscribe to such metaphysical concerns perpetuated by the naming of source and target”. While sympathetic to her concerns, I fail to see how “host” and “guest” are any less metaphysical.
Rather, the discourse of “national character” already had a complicated and long track record by the time LX encountered its application to the “Chinese” by way of Japanese translations of Arthur Smith’s 1894 monograph *Chinese Characteristics.* Long before being applied to Asia, theories of national character were developed both to explain differences between and to establish the unique identities of various peoples in Europe. Even after World War II the idea of national character served as a theoretical orientation within the field of psychological anthropology, as is evinced by the studies of famous academics like Margaret Mead and Ruth Benedict. At the turn of the twentieth century, however, theories of national character were intimately tied to colonialism and imperialism. While on the one hand imperialist nations used the theories to justify or rationalize their efforts, reformers and revolutionaries in China used the theories in attempts to avoid some of those same imperialist influences and to effect national change; Liang Qichao was one such figure and Sun Yat-sen another. What is so important about the idea of national character, however, is not whether it was predictive, accurate, or believable when we consider its various forms upon retrospective investigation. Instead, its significance lies in the fact that it was believed and perpetuated broadly in the popular imagination of the time. This is precisely the key issue that Liu does not address when she writes that Arthur Smith was a key player “in the invention of the myth of Chinese Character” that later turned into the “ambivalent reinvention of that myth by the Chinese themselves, especially in the May Fourth literary discourse.”

One is reminded of Alasdair MacIntyre’s discussion of such roles of literature in *After Virtue* where he writes:

> Heroic societies, as they are represented by the Homeric Poems or the Icelandic or Irish sagas may or may not have existed: but the belief that they had existed was crucial to those classical and Christian societies which understood themselves as having emerged from the conflicts of heroic society and which defined their own standpoint partially in terms of that emergence.

That is to say, it is important not to neglect the distinction between questions of fact and questions of what is believed broadly. For our own purposes, my claim is that LX and many Chinese believed

265 Liu, *Translingual Practice*, 47.
the information available in the writings of Smith and others. Such belief had consequences and made space for discussing the transformation of the Chinese person.

In the same manner that laughable views regarding the *tafusagi* and other such matters had an impact on how neurasthenia was conceptualized in Japan, ideas regarding national character in China also had their impact. Retrospective hostility to the “myth” should not hide from view the large-scale ramifications on the local world that such an idea would have effected when treated as though it were not a myth at all but a matter of fact. Despite whatever we think of it today, “the myth of national character” was no myth for LX or other influential figures of China’s New Culture and May Fourth movements. This claim should be relatively uncontroversial, and for that reason I lean on it in the process of defending the notion that neurasthenia began as a cultural *asset* in China.267 While it may seem like a stretch to relate LX and the myth of national character to the entrenchment of neurasthenia in China, I believe there are very good reasons for doing so, especially given the prevailing theories of neurasthenia offered in psychiatric/medical literature in the United States. Let me begin with the caricature of Chinese characteristics in the early twentieth century, which LX and others seemed to accept as factual.

It has been claimed that Arthur Smith’s book contains a “contemptuous” metaphor for the Chinese people that “no doubt reflects the author’s racist attitude toward the Chinese”.268 While the book also contains expressions of admiration for the Chinese people,269 it is unfortunately true that the book is, in the main, overwhelmingly negative in tone. As can be seen from its chapter headings alone, the book contains a great deal of negative topics for discussion. For instance, we find that he wrote about the concepts of “face”, “disregard of time”, “disregard of accuracy”, “the talent for misunderstanding”, “the absence of sympathy”, “the absence of nerves”, “the absence of

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267 This is a claim that I have not seen anyone make regarding the popularization of SJSR in China. It was not a national burden originally; it was an asset.

268 Liu, *Translingual Practice*, 57. It is not clear at all that the term “racism” should be applied to Smith. It is probably better to reserve that word for those who believe that members of a particular group are innately inferior as a result of something intrinsic to the specific group and its individual members themselves. In other words, racism implies a presumed inferiority that is not a matter of mere contingency (e.g., Intellectual inferiority resulting from organic brain damage, lack of education, or other contingent feature that is not a necessary attribute of the group). Smith is more appropriately an ethnocentrist, elitist, nationalist, or jerk; but it is not clear that he was a racist in any manner remotely resembling those who believed that Africans were intrinsically of less value or dignity than white Europeans because of some innate attributes they were thought to have had as a necessary condition of being African.

269 For example, he states that one “of the many admirable qualities of the Chinese is their innate respect for law” and that “the Chinese are by nature and by education a law-abiding people” (237).
sincerity”, “the absence of public spirit”, “contempt for foreigners”, “indifference to comfort and convenience”, and a host of other notions that are aimed at pointing out the uncivilized status of Chinese society. Furthermore, it would not be surprising if we were to find out that the Japanese-language edition available to LX had removed even those few entries where Smith praises the Chinese people. Nevertheless, we do not need to know exactly which copy LX was reading in order to get a sense that his early writings served to personify and re-present to his countrymen those aspects of Chinese character that he believed were a barrier to national advancement; in fact, such a reading of his works is commonly assumed. There can be little doubt today that LX did read and reflect over Smith’s book. In Mashang Zhi Riji (1926), he recounted a visit to a Japanese bookstore and the purchase of a Japanese work on Chinese national character purported to study the topic from the perspective of fictional literature. His description of the table of contents is similar enough to Smith’s chapter headings that the narrator opines that “he seems really to believe Smith’s Chinese Characteristics”.  

He goes on to state that the Japanese have had translations of Smith’s work for over twenty years under the title 支那人氣質, but that “we Chinese have not paid much attention to the book”. Interestingly, although LX refers to twenty years of access to the text, Shibue Tamotsu’s translation dates to 1896, some thirty years earlier, as can be seen in Figure 1. Confident in the historical access LX had to Smith’s work in Japanese translation, we can consider what LX was after. Present purposes do not require a detailed look at all the change he hoped might occur in his countrymen; but for some clarification, it is worth a very brief discussion of those aspects of national character that he thought needed remedying.

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270 Xun Lu, Lu Xun Quan Ji, (Ren min wen xue chu ban she, 1973). See his “Mashang zhi riji, qi yue er ri qing” (马上支日记, 七月二日晴).
271 Ibid. “二十年前就有譯本，叫作《支那人氣質》；但是支那人的我們卻不大有人留心它.”
272 洪江保 (1857–1930).
3.3.3 Lu Xun and Ah-Q

If ever it could be said that a single character maximally personified those traits described in Smith’s chapter headings, it would be true of the protagonist in *The True Story of Ah-Q*. In fact, LX suggests as much when, around 1933, he wrote that the purpose for having penned the story was “probably to expose the weaknesses of the Chinese citizenry”. An examination of Ah-Q readily presents us with a figure who neatly fits into Smith’s caricature. He is driven by preoccupation with “face” in regards even to the most insignificant of matters, such as competing with another vagabond over who can make the loudest popping sound when biting a louse. He has

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contempt for things foreign, has no regard for time, has a talent for misunderstanding and re-interpreting affairs to fit his own needs, lacks any public spirit, is insincere, and is generally indifferent to comfort and convenience. What’s more, Ah-Q’s celebratory retelling to his townsmen the story of a beheading that he has allegedly witnessed, takes the reader directly back into the classroom scene of LX’s early experience in Sendai as described later in the preface to NaHan (呐喊). Contemporaries could certainly be exposed to Smith’s critique of the Chinese character, though not necessarily from reading his book, by seeing in LX’s protagonists those depictions of a national character that Smith believed he had recognized.

This is most readily demonstrated by considering one of the more vitriolic attacks on LX’s work. With the publication of “Siquele de A Q Shidai” in 1928, Qian Xingun engaged in a rabid assault of LX’s fiction, claiming that it was ideologically deficient, unfit for any readership, and lacked any relevance to contemporary China.274 Despite the pages of insults hurled at LX, Qian does in a few instances offer recognition that Ah-Q served well as a representative of the “aberrant national character” and “mass ideology” in the period before the beginning of the May Fourth Movement.275 Interestingly, Qian criticized LX not for his apparent acceptance of the myth of national character, but because he believed the portrayal of Chinese character accurately applied only within a particular timeframe. In other words, he thought it was accurate, but that it no longer fit after the May 30th uprising of 1925. Analysis of such an opinion is beyond the purposes of the present discussion; but it is worth pointing out that Smith’s “myth” was believed and that there was a desire to have the citizenry eventually outgrow the traits of which it was accused. Most importantly, Qian’s grossly naïve hermeneutic failed to recognize that LX’s narrator might himself already serve as a counter-example to Ah-Q and as a foreshadowing of a future citizenry to come. A similar issue has clued scholars into LX’s self-positionality with respect to the criticisms of Chinese national character.

One of the ways in which Liu and other contemporary scholars have addressed considerations of national character and class division in LX is by examining how he situates the relationship between narrator and protagonist. Liu came to this question via LX’s ambiguous third-person commentary: “Twelve years ago, Lu Xun produced a story called The True Story of Ah-Q.

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275 Denton, Modern Chinese Literary Thought, 285
intending probably to expose the weaknesses of the Chinese citizenry, although he did not make clear whether he was himself included among those with such weaknesses.” 276 In consideration of this ambiguity, Liu concludes that LX’s “story creates not only an Ah-Q but also a Chinese narrator capable of analyzing and criticizing the protagonist”, which then “supersedes Smith’s totalizing theory of Chinese character”. 277 Regarding this very interesting insight, it is worth making two addenda. First, it should be very clear that LX did not “create” an Ah-Q ex nihilo; the substrate for the character was readily available. This is the point I have been trying to emphasize—whatever one thinks of the character, it appears to have been readily accepted as a reasonable re-presentation of something experientially available to contemporaneous persons and in need of remedy. More important yet is the second part of Liu’s conclusion. From this perspective, not only is Qian’s criticism of LX completely undermined, but insight is also gained into LX’s not clarifying whether he was himself possessed of Ah-Q’s deficiencies. Liu seems correct in suggesting that, at the very least, the narrator is exempted from some, if not all, of those weaknesses. LX’s fictional narrator(s) is no Ah-Q, which though a simple detail overlooked by Qian and others, interjects a counterexample into the discourse of national character. Such an interjection was a necessary first step to making way for a narrative of racial progress. This type of literary and epistemological disparity between writer/narrator and the characters within the narrative is nothing new. Alasdair MacIntyre referred to this as well. Writing about Homer’s construction of the Iliad he pointed out:

> Achilles in his moment of reconciliation with Priam had no way of representing to himself what Homer is able in his account of Achilles and Priam to represent to others. Thus the Iliad puts in question what neither Achilles nor Hector can put in question: the poem lay claim to a form of understanding which it denies to those whose actions it describes. 278

In like manner, the narrator of Ah-Q’s story lay claim to an awareness, sensibility, and understanding that is denied to Ah-Q himself. Given such a hermeneutic frame, LX’s intention of positioning his narrator as a counterexample to Ah-Q situates the remainder of our discussion.

3.3.4. Ah-Q and Three Views of Chinese Nerves

The question now arises as to what LX’s depiction of Ah-Q has to do with neurasthenia. While I do not believe that LX was thinking specifically about SJSR while crafting his protagonist,

276 Lu, Lu Xun Quan Ji.
277 Liu, Translingual Practice, 76.
278 MacIntyre, After Virtue, 128. Emphasis in italics is mine.
it seems likely that he was aware that Ah-Q was the very antithesis of the kind of person who came down with the ailment of SJSR. Ah-Q was the anti-neurasthenic who, though susceptible to so many weaknesses, was incapable of the type of weakness that was believed eventually to give rise to neurasthenia. Are there really any grounds for making such a suggestion, or is this just an imaginative stretch? To make sense of this claim, it is necessary to consider all that has been discussed thus far in light of (1) Beard’s view of China, (2) Smith’s view of Chinese nerves, and (3) LX’s own diagnosis. I will take these up in order in the hope of convincing the reader that neurasthenia does have something to do with the sick man of Asia that LX wanted to see healed, as I find this fertile ground for SJSR’s sprouting forth in China and necessary background for discussing its growth and subsequent uses in that country.

Let me now turn to Beard’s view of China. Recall that in both Nervous Exhaustion and American Nervousness, Beard presented his case that the rise of neurasthenia as a clinical ailment was especially an “American disease”\(^\text{279}\) that was the result of living in a modern, civilized society with all the concomitant over-stimulation such a life entails. It was the plight of brain workers rather than muscle workers,\(^\text{280}\) and was not a common phenomenon found in charity or poor houses. When considering “life in ancient Athens and New York contrasted”, modernity was seen as the culprit that brought the overbearing stressors of job specialization, clocks and watches, telegraphs, noise, railway travel, new development, increase in business, buying on margin, domestic and financial troubles, and other such forces.\(^\text{281}\) Beard even commented on the unique case of America’s extreme differences in hot and cold climates, which could affect the nervous system. Considering Beard’s overall project, it is extremely interesting to find that he chose to compare Japan with America. The desire for modernization that was present in Japan at the time of Beard’s writing makes it all the more so. He began his comparison by recognizing between Japan and the USA similar extremes in climate, which he thought could affect those whose physical constitutions had become or were naturally susceptible. While writing in 1881, just twelve years after his debut article on neurasthenia, which happened to coincide with the start of the Meiji restoration, Beard wrote, “In the Japanese, however, we see suggestions of a fineness of type which is peculiarly American; and had the Japanese obtained civilization which, in institutions and intensity had even

\(^{279}\) George Miller Beard, American Nervousness, Its Causes and Consequences: A Supplement to Nervous Exhaustion (Neurasthenia) (Putnam, 1881), 9
\(^{281}\) Ibid., 101–35.
approximated that of America and Europe, it is not improbable that they might have developed a nervous susceptibility which, in their present condition, does not exist”. As I discussed at the beginning of this chapter, we now know that, by the last decade of the nineteenth century, neurasthenia had become entrenched in Japan in a manner that would not occur in China for another quarter of a century. Recall from Beard’s writings that there was some ambiguity regarding who could develop neurasthenia. As we have seen here, he believed that the Japanese had an innate susceptibility to the situation of being vulnerable to nervous weakness; but he also thought that the refinement that made one susceptible could be cultivated, at least over generations. However, specific social institutions and forms of life must be in place, which would then precipitate the diseased state. As noted previously, electricity, telegraphs, railways, and other forms of modern life were seen as major contributors acting on susceptible nervous constitutions. Given such views, Beard would not have been surprised to learn that, from the time of his debut paper to the publication of *American Nervousness*, Japan underwent a major transformation that would shortly precede its concerns with neurasthenia. For instance, during the same period it went from being completely without any railway to its first running locomotive in 1871, the establishment of around 250 miles of tracks, and the founding of Nippon Railway in 1881. By the end of the century, the nervous susceptibility, for which Beard could say it “does not exist”, had come into existence in full force. Unfortunately, Beard died in 1883, just two years after the founding of Nippon Railway, and he and was not able to witness his idea spread to Japan and explode in the popular understanding, as it did by 1900. Neither did he get to see it enter China, which, from comments he had made regarding the Chinese people, is something he would have expected even less.

For whatever reason, Beard thought it necessary to offer his opinion on the state of upper-class Americans in relation to the Japanese, explicitly setting both apart from Chinese people: “This is certain; that the Japanese, even of the lower orders, are of a far finer type than the Chinese, or any of the nations of the Orient, and that the Japanese woman of the higher classes . . . is of a

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282 Ibid., 162–63.
283 Comically, Beard’s view of the Japanese is that they were susceptible to nervous susceptibility, but they did not yet have the institutions to develop that nervous susceptibility. In other words, this amounts to a “susceptibility to susceptibility”. As absurd as this sounds initially, it is closely related to the notions of necessary and sufficient conditions for disease.
284 Recall from the previous chapter how the growth of railway in England and the US coincided with a host of nervous complaints. By the mid 1870s, the length of rail was to double, with rapid growth continuing each year. For a delightful history of Japanese railway see the following: Dan Free, *Early Japanese Railways 1853–1914: Engineering Triumphs That Transformed Meiji-Era Japan* (Tuttle Publishing, 2008).
sensitiveness of organization and a grace and delicacy of manner that suggest the highest types, as we meet them in the very highest civilization”.

In other words, the father of neurasthenia proclaimed that the disease of his discovery was one that occurred among those people with the greatest sensibilities and sensitivities when the strains that could come only from advanced and modern society began to take a toll on the susceptible constitution. Such an ailment could befall the American and European first, and then the Japanese; but it was unlikely to occur among the Chinese who he believed lacked the refinement of constitution and innate sensibility and sensitivity, as well as lacked any of the social institutions that made such a condition possible. Beard’s positions were very much the product of an era permeated with discourses of national character that emphasized and delineated those traits believed to distinguish one particular group from another. It is quite ironic then, that within one century of his writing, China would be the world’s primary setting for neurasthenia as a medical diagnosis.

Having discussed Beard’s view of China, let me turn momentarily to Smith’s view of Chinese nerves. Writing only a decade after Beard’s death, Smith would have been very familiar with the discourse of nerves and nervousness as discussed in Chapter 2. In fact, he included his own chapter (Chapter XI) specifically on the “absence of nerves” among the Chinese. The chapter begins with some commentary about the concept of nerves as it was popularly known in Western countries. He wrote that “it is a very significant aspect of modern civilisation which is expressed in the different uses of the word ‘nervous’ . . . The varied and complex phraseology by which the peculiar phases of nervous diseases are expressed has become by this time familiar in our ears as household words. There is no doubt that civilisation, as exhibited in its modern form, tends to undue nervous excitement, and that nervous diseases are relatively more common than they were a century ago”. This “familiar” concept of nerves, as I have attempted continually to demonstrate, was hardly separable from the notion of refinement both in character and sensibility. Such refinement was a necessary, but not sufficient, condition for nervous disease and only made “nervous susceptibility” possible. With this as context, Smith continued: “But though the nerves of a Chinese as compared with those of the Occidental may be, as the geometricians say, ‘similar and similarly situated,’ nothing is plainer than that they are nerves of a very different sort from

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285 Beard, American Nervousness, Its Causes and Consequences, 162.
286 Shibue’s translation in Figure 12 is 無神経, with English added as “absence of nerves”.
287 Smith, Chinese Characteristics, 90.
those with which we are familiar”. He suggested that the Chinese, when compared with the European, were more tolerant of pain, less susceptible to fatigue, able to sleep without being affected by disturbances, and less susceptible to anxiety, among other aspects of not being of a “nervous” constitution. He concluded by wondering who might be better adapted for survival in the twentieth century, the “nervous” European or the phlegmatic Chinese.

The sociohistorical context in which LX encountered Smith’s book is very different from our own. For instance, it is interesting to find that the more contemporary Chinese translation of Smith’s book readily available to the reading public over the past thirty years translates his eleventh chapter as “bujin buman”, rather than making any reference to nerves. Whether the translation has something to do with Chinese reinterpretation or is just a failure in comprehending the original author, I am not certain. The most recent translations have done a better job at approximating Smith’s meaning, but they have also made substantial changes. One must always be weary when a translation of a text alters the arrangement of chapters, in this case turning the original eleventh chapter into Chapter 18. That is what has happened in Li’s new translations, where “absence of nerves” becomes “duo-xing”. In these instances, the translations are separated from the discourse of nerves elaborated in the previous chapter, which gives a grounded meaning to a reference like shenjing. These alternative renderings may demonstrate to us that translators today find the phrase “without nerves” (meiyou shenjing) to be less than clear, as it lacks the theory-laden sense that it once had, and “nerves” are now an entrenched part of the lexicon in both Chinese and English, with meanings quite different than used to be the case. Additionally, China did not undergo the extensive history of nervous discourse as outlined in the previous chapter, but

288 Ibid., 92.
289 Ibid., 90–97.
290 史密斯, 中国人的性格 (学苑出版社, 1998). (Le Aiguo, Zhongguoren de xingge). The term “bujin bu man” (不紧不慢), which references a sense of peace of mind or otherwise lack of concern regarding a pending outcome, is a far cry from the lack of sensibility and lack of refinement that Smith intended. This is probably most clear by looking at original Japanese translations as well as Pan Guangdan’s translation, all of which I will mention only in passing.
291 史密斯, 中国人的性格 (青苹果数据中心, 2014). (Li Mingliang, Zhongguoren de xingge). “Duo xing” (惰性) is a term used in organic chemistry to refer to an inert substance. It can also mean “apathy”, “inertia”, or “laziness”. This is closer to Smith’s meaning, but it is not embedded in the nervous discourse of that period.
292 To say, “you don’t have any nerves” in English today would not mean anything near what it did in Beard’s day. In like manner, if you said “ni meiyou shenjing” (你没有神经) to a contemporary Chinese person, they would have no idea what you were talking about. If anything, the Chinese listener might think you meant that they were not crazy.
instead jumped directly to a discourse of neurasthenia. Still, if these contemporary translations had been used in LX’s day, readers would likely have missed the implication of a Chinese deficiency in sensibility, refinement, and susceptibility that, in Smith’s mind, set apart the Westerner from his Asian counterpart and in some ways disadvantaged the modern European with the burden of nervousness.

Having considered Beard’s view of China and Smith’s view of Chinese nerves, let me now return to LX with consideration of his own diagnosis in the context of his day. What is one to make of Smith’s claims above, and what would LX have thought upon reading the “nerves” chapter of Smith’s book? We can be somewhat confident of his endorsement of certain other sections of the text, and so I therefore suggest that he also recognized something about this particular chapter that also resonated with his experience of his countrymen. However, as I have made explicit, I think that LX believed that there existed ready exceptions to Smith’s criticism, the representative example of which was LX himself.

In the mid-1800s, flagrant insanity was prevalent enough that John Kerr founded a welcome hospital for the insane in Canton in 1898. The concept of nervous disorders was a different matter, however. The claim that Chinese people could be characterized by an absence of nerves was oft repeated at the beginning of the twentieth century, and it found its way into the most prominent medical journal of those working in China at the close of the nineteenth century, the China Medical Journal. An editorial in 1889 made the claim that nervous and mental disease was relatively infrequent in China. Nervous disease was, on the other hand, considered to be rather common among foreign missionary workers. The 1915 edition of the China Medical Journal reported that American physicians often employed the diagnosis of neurasthenia in China with regard to other foreigners. In fact, under the stress of life in the new republic and its warlord contenders, 44.8% of missionaries were reportedly suffering from the condition. In the same year, there appeared Chinese language advertisements running daily for patent medicines claiming to cure neurasthenia, a presumably new ailment for Chinese people, as well as other previously known ailments like semen loss and impotence. The obvious question is who those advertisers were targeting, as the ads often ran daily for weeks at a time (Figure 13 is one such example).

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293 For a description of the Kerr Refuge for the Insane, see Chinese Medical Journal xxii, no 2 (1908): 82–91.
There is an obvious tension in the argument I am trying to make here. On the one hand, there appears to have been a prevailing notion among Westerners that nervous ailments were “remarkably infrequent in China” among the Chinese, as it has been variously put in writing. 296 On the other hand, advertisers considered it worthwhile to begin marketing medicines for

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295 This add ran daily for almost a month in 1915. Another variation of it read as follows: Western medicine scholar Xiao Zhiji with African bark pills effects special treatment of neurasthenia, nocturnal emission, impotence (“西醫學土蕭智吉同鑑定非洲樹皮丸功能健腦固精專治神經衰弱遺精陽萎之聖品”), Shen Bao, 1915.

neurasthenia to those Chinese urbanites reading *Shen Bao*. The balance between these two facts appears to lie in the term “infrequent”, with a special consideration of those elites like LX who straddled the transition from the period of Ah-Q to a “modern” China, and this may shed some light on the indignation of Qian mentioned above. In other words, while Qian appears to concede that Ah-Q was a reasonable representation of a large number of Chinese prior to 1925, the typification no longer held by the time of its publication in 1921. This brings me to the consideration of LX’s diagnosis, which he received in a Japanese-named clinic after his final return to China. He recounted in his diary from August of 1912 that he “suffered a few days from cough with concern that it was bronchitis and visited Ikeda clinic this morning. The physician said it was not serious, only a neurasthenic condition. Liquid and powder medicines for two days each came to a price of one yuan, two jiao. The initial visit was two yuan”.

LX seemed to understand the discourse of national characteristics, and certainly had read Arthur Smith. He was aware of the “sick man of Asia” label, and constructed Ah-Q as the personification in a single individual of all that was described by Smith. With his experience of studying medicine in Sendai, Japan, and having navigated daily life in the Japanese language, he almost certainly was aware of himself as non-representative of the larger Chinese population. His neurasthenic condition, which he chose to document in his diary, was another trait that separated him from all those Ah-Qs with their “absence of nerves”. As is well known, he eventually turned to writing literature in order to provide healing to his countrymen. It was the existence of such exceptions, and their susceptibility to nervous exhaustion, that made it possible eventually to claim equality with other peoples of the advancing world and bring modernity to China.

If I am sincere that the reader should take everything I have stated thus far seriously, then how can I explain that LX did not mention SJSR in *The True Story of Ah-Q*? The answer to this question has two parts: first, the phenomenon of SJSR is not an explicitly necessary criteria for being modern; and second, at the time that LX penned the story in 1921, his ideal of a modern Chinese man was less formed than his conception of what was backward about the actual Chinese man. As the suitability of the Ah-Q criticism waned, LX did explicitly make reference to SJSR on a number of occasions. Besides his personal diary, the earliest such reference is the satirical poem, “My Lost Love” (*Wo de Shilian*) in 1924, which appeared in *Wild Grass* (野草 *Ye Cao*)

297 I mean “typification” in the sense Alfred Schutz described it.
in 1927. There are multiple other references to SJSR that occur later across LX’s corpus, in nine other texts overall, but those individual cases are not the subject of our inquiry. More important for our purposes is the development of a general sense of what SJSR was beginning to mean for Chinese people. In Japan, neurasthenia was something that first affected those elites who lived as modern intellectuals. Afterwards, it was a plague on a nation that had modernized too quickly without keeping traditional ways of life. In China, SJSR was a new possibility of experience for people like LX who had made some progress toward becoming disentangled from the backwardness of China’s past. This was true for other writers and intellectuals, as SJSR was entering the lexicon of everyday use. It was a category of experience that, from the Chinese vantage point, had been entrenched in its Euro-American-Japanese origins and could newly be employed both to explain various phenomena in a changing China as well as to make money. I will return to its employ in the Chinese literary scene after a brief diversion into non-fiction and some commercial matters.

3.4 Neurasthenia in Popular Discourse

In 1937 sociologist and eugenicist Pan Guangdan (潘光旦) translated Smith’s book into Chinese with the section on the “absence of nerves” titled “meiyou shenjing de zhongguo ren”. By that time, SJSR had already been in semi-regular use for two decades or more, and Smith’s claims could be applied to fewer and fewer people. Intellectuals had long been bringing the concept to public attention, as noted earlier in this chapter. Recall that Kleinman listed 1923 as the earliest date he could find reference to SJSR, and Peng Hsiao-yen mentioned the earliest book she could find on the subject was one published in 1917. Aside from monographs, however, there are materials of historical interest that demonstrate an attempt to spread awareness of the phenomenon even earlier, before the establishment of the Republic of China. The following section deals with such materials, which demonstrate the increasing availability of information about SJSR to readers of what might be considered special interest non-fiction. The common thread among them is a relationship to knowledge coming from Japan.

298 The relevant line reads, “從此翻腸不理我，不知何故兮使我神經衰弱”.
299 Guangdan Pan, Pan Guangdan Wen Ji, vol. 3 (Beijing da xue chu ban she, 1993), 57:“没有神经的中国人”.
3.4.1. Special Interest Publications

One early example is seen in “Method for preventing Shenjing Shuairuo”, which was printed in Dalu (大陸) magazine in 1905.300 Published by a press called the Xinshe Book Bureau (新社图书局出版) in Shanghai starting in 1902, Dalu was an edited periodical at the end of the Qing dynasty that was to shut down publication in 1906. Originally printing as a monthly, but later increasing to bimonthly production, the magazine was founded by Chinese students who had returned from study abroad in Japan. It covered a variety of topics including news, political editorials, and health information. While readership was probably very small and limited to an intellectual and student class in Shanghai, it is one example of early efforts to spread knowledge gained abroad. The information provided about SJSR seems consistent with Beard’s general framing of neurasthenia. The basic claims are straightforward: SJSR is not acute but gradual; it affects one’s ability to attend to details; causes one to feel ill at ease and irritated without much provocation; and leads to poor sleep. Its etiology includes overwork of body or spirit (精神), inadequacy of nutritious eating habits, inadequate time set aside for rest, excessive toil, and lack of peaceful sleep. Primary prevention was to include proper diet, avoidance of excessive toil, and establishing good sleep habits, which included eight hours of sleep per night (一日必須八點鐘). The theoretical basis for such advice was simple, “everyone’s mental power has its limits, people differ in strengths and weaknesses; if you over expend your spirit (精神) and don’t fully recuperate, your nerves will of necessity gradually weaken”.301

More specialized journals also brought knowledge to China from overseas. One such Journal of Medicine (醫藥學報) founded in Chiba prefecture, Japan, in 1907 made professional information available in classical Chinese. Founded by several Chinese studying in Japan, the main columns consisted of medical theories, miscellaneous records, popular speeches, essays, historical biographies, and lectures. The magazine’s aims were to advance new theory, study practical science, and seek medical reform and pharmaceutical progress in China. In 1909 an article titled “Neurasthenia of Brain” offered explanation regarding the meaning of SJSR.302 As was the

301 The text on page 2 reads: “凡人之腦力有限。雖強弱有差。然無論如何強健之人。苟自晨至夜。耗費精神。而不十分休養之。則神經必漸次衰弱。”
common thinking, it was claimed that originally the ailment was rampant in the USA as a result
of her early development (美洲開化最早) and earning SJSR the title of “the American disease”
(亞美利加病), all of which is consonant with the picture of neurasthenia originally offered by
Beard. Unlike Beard, the article reported that with more research it was becoming understood that
the disease existed in the “old world” and in all places, although nothing more of any detail is
offered. The remainder gives much of the same symptomology previously covered, pointing out
that exhaustive listing is impossible due to the numerous manifestations, which are divided into
bodily and mental symptoms. For the body there are varieties of headache, tinnitus of one or both
ears, insomnia, and fatigue following any activity such as eating, talking, exercising or changes in
weather. The mental symptoms are not dealt with in any detail in the paper.

From the perspective of religious, special interest groups, there were also missionary
papers such as the Jesus’ Teaching Family News (耶稣教家庭新闻), which was produced by a
Presbyterian mission board that spread updates in information regarding missionary activity,
advances in medicine, and political happenings relevant to the churches. In 1909 we find a
retelling of something recently published in the magazine Riben Jiating (日本家庭). It reported
that the Japanese magazine had offered three means of avoiding SJSR. The advice was to (1) avoid
hereditary taint, by not marrying a girl with any family history of the disease; (2) stop drinking
and smoking (tobacco and opium); and (3) do not overburden oneself with excessive responsibility
or the obligations of either physical or mental labor.

While special interest publications not unlike those mentioned here had long existed in the
late Qing, and Chinese print history further predates the interest in foreign learning found in the
first decade of the twentieth century, it is fair to say that something changed in the years leading
up to the founding of the Republic in 1912. In addition to the revolutionary interests in publishing
during the waning of the Qing, there were practical matters of entrepreneurship that also
contributed to the types of materials available in print. For instance, we might consider some of
the changing demands of readers. Christopher Reed has pointed out that the “abolition of the

303 Of course, there was also the English language literature being exchanged within the pages of the Chinese
Medical Journal, previously titled the Chinese Missionary Medical Journal. That journal has already been
mentioned in passing. The journal discussed here, 耶稣教家庭新闻, might be better translated as “Christian family
News”, but I am not aware of how the title was originally translated. I have chosen “Jesus” because the term 耶稣
is generally translated as the name “Jesus”, while 基督/基督教 is generally translated as “Christ/Christian”.
traditional education curriculum and of the civil service examination system in 1904-5 meant that, just as the necessary adjustments had finally been settled into, Chinese modernity was redefined with an emphasis on ‘new-style’ learning and books that addressed political and social problems with reference to Japan and the West, rather than to China’s ancient greatness”.\textsuperscript{305} This is in part to say that, among other factors, publishers were not going to profit from continuing to print the types of materials previously demanded by those preparing for examinations. This is not meant to diminish the fact that there had long been readers interested in popular fiction printed under the genre of what was to be called “Mandarin Ducks and Butterflies”. Much of that literature, however, was printed not as monographs, but as serials in weekly or monthly papers.

The complete picture of the types of changes that were occurring in China from 1911–1920 are so complex that they take up countless volumes. From the founding of \textit{New Youth} by Chen Duxiu in 1915, what was to be known as the New Culture Movement served as a platform for changing views of self and society.\textsuperscript{306} The meaning and role of the novel, and fiction generally, became a deeply and acridly contested matter after the inception of the May Fourth Movement of 1919 as it furthered what had begun in the New Culture Movement.\textsuperscript{307} This is evinced by the development of competing theories of literature that were represented by a variety of literary societies from 1920 onward.\textsuperscript{308} Those debates on literature required access to large-scale printing

\textsuperscript{305} Christopher A. Reed, \textit{Gutenberg in Shanghai: Chinese Print Capitalism, 1876–1937} (UBC Press, 2004), 90.

\textsuperscript{306} The founder of New Youth (新青年) was also a leader of the May 4th protests and a founding member of the Communist Party in China. The inaugural issue of New Youth listed the following six challenges for the new youth of China to accomplish: (1) Be independent and not enslaved 自由非奴隶; (2) Be progressive and not conservative 进步非保守; (3) Be in the forefront and not lagging behind 进取非退隐; (4) Be internationalist and not isolationist 世界非锁国; (5) Be practical and not rhetorical 实利非虚文; and (6) Be scientific and not superstitious 科学非想象.


\textsuperscript{308} Michel Hockx and Kirk A. Denton, \textit{Literary Societies of Republican China} (Lexington Books, 2008).
capabilities, which had been undergoing development since the late nineteenth century. A transformed printing culture, it has been argued, made for a transformed population.\footnote{Reed’s study of printing in China from 1876 to 1937 is a staggering look at the multiplicity of factors that influenced the types of printing presses that were initially used, rejected, modified, and improved upon in China’s march toward an autonomous and modern print culture. He draws an analogy with Europe where access to printing presses disrupted the hegemonic influence of the Roman Catholic Church, opening up possibilities for competing theological and political narratives. In like manner, access to printed information made possible the rise of the Chinese Communist Party and the eventual founding of the People’s Republic in 1949.}

### 3.4.2 Shen Bao and Medical Advertising

Momentarily continuing with the present aim of setting aside fiction, one example of such a transformation might be seen in the role printed newspapers may have had on the formation of a Chinese concept of self. By studying the content published in the newspaper *Shen Bao*, Weiping Tsai has taken up this matter of how reading consumers participated in the negotiation of their own individuality vis-à-vis loyalty to the nation, consumer culture, hygienic practices, and other matters of everyday life.\footnote{*Shen Bao* (申報) was an abbreviation for the name *Shenjiang xinbao* (申江新報), where *Shenjiang* is itself a shortened form of the name *Qunshenjiang* (群申江), yet another name for the Huangpu river (黃浦江) that flows through Shanghai.} Whether Tsai accomplishes his task of demonstrating a growing tension between self/nation and public/private among the readership of *Shen Bao* is not worth arguing presently. More important is his argument that print material, and *Shen Bao* in particular, served as a force for changing views in early twentieth-century China. When considering that paper, it is surprising to see how a publication started by an Englishman (Ernest Majors) in 1872 could eventually end up in domestic hands (taken over by Shi Liangcai in 1912, who would come to own majority share in the company) and expand to the point of truly mass production. For example, in 1916 the company purchased a Japanese-made rotary press that could produce 8,000 pages per hour.\footnote{Reed, *Gutenberg in Shanghai*, 77.} By 1918, they purchased an American cylinder printing machine capable of more than 30,000 copies per hour. In subsequent years, more machines were purchased, and printing schedules were made to match train timetables in order to deliver the papers outside of Shanghai.\footnote{W. Tsai, *Reading Shenbao: Nationalism, Consumerism and Individuality in China 1919–37* (Springer, 2009), 12.} It was the mass production and commercial focus that has contributed to much of the historical interest in *Shen Bao*’s readership. Unlike many earlier papers that had a clear revolutionary or reform purpose,\footnote{For a scholarly look at one such paper, see: Joan Judge, *Print and Politics: ‘Shibao’ and the Culture of Reform in Late Qing China* (Stanford University Press, 1997), 30.} *Shen Bao* appeared to be primarily about making a profit. This is not to say that

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no political ideology was expressed in its pages, as Tsai clearly points out; but even the political material was often aimed at increasing sales of a particular product.Rather than viewing the reception of commercial material as a passive process, scholars like Tsai and others have seen a mutual exchange going on within the market that gave rise to the various advertisements and information exchanges in *Shen Bao*.

Huang Kewu has put this succinctly in his study of medical and medicinal advertisements in *Shen Bao* from the founding of the Republic of China through 1926. He suggests that the readers are most appropriately viewed as “searching through the papers actively seeking out information that might resolve problems they were having in their lives, and the advertisements produced by the market needed to match up with consumer needs in order to be effective as advertisements”. Among the empirical findings from Huang’s study, one of the most salient is that all advertisements for general hospitals appearing in *Shen Bao* during that period were for Western medical hospitals rather than hospitals of Chinese medicine, of which there were more actual buildings. On the other hand, advertisements incorporated a variety of medical theories, which ranged from Western to Chinese traditional and folk medical theory. In the period even before Huang’s study, we can find advertisements appearing in *Shen Bao* that appear to draw from a global market influence. Recall the Sears and Roebuck advertisement for an electric belt in Figure 10 of the previous chapter. Only three years after appearing in Sears and Roebuck, ads for very similar products appeared in *Shen Bao*, as can be seen in Figure 14 below.

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314 For example, Tsai dedicates a chapter to the role of the “national products” movement, which attempted to guilt readers into buying Chinese rather than foreign cigarettes.


316 黃克武, “從申報醫藥廣告看民初上海的醫療 文化與社會生活, 1912-1926,” 143. The original reads, “他們常常是主動地尋找需要的資訊來解決生活問題,而廠商所作的廣告亦須配合消費者的需求,才可能達到宣傳的效果”.
Figure 14: Shen Bao, 1905年04月20日 第8版 第11495期

Detail: 電帶防疫 (Diandai fangyi) “Electric belt prevents disease”
Figure 15: Shen Bao 1905 年 11 月 30 日 第 15 版 第 11719 期
Detail: 衛生電帶冬令要需 (Wèishēng diàn dài dōnglíng yào xù) “Hygienic electric belt for winter needs”
Running daily for weeks and months at a time, such images and concepts were either ignored, were seen but eventually forgotten, or were imprinted on the minds of readers. As the second decade of the twentieth century progressed, and the scale of printing continued to expand, Chinese readers were increasingly exposed to imported concepts through commercial advertisement imaging. I have included some of these images because of their ability to capture readers’ attention and their similarity to commercial efforts in the USA around the same time, but it should not be ignored that the images are often accompanied by the written word, which further provided conceptual information for the reader. Additionally, image-free print space containing SJSR content was also ubiquitous in the newspapers of the day.

One such advertisement column on a front page of Shen Bao serves as a representative example of the type of material that contained only text (Figure 16 below). The text of this 1925 commercial piece is presented under the title, “Effective Medicine for Shenjing Shuairuo”. While SJSR appears as the targeted ailment for the patent medicine being offered, the actual text that follows does not explicitly use the term SJSR. Instead it refers to a general category of “nerve-weakness”. The full text can be found in the caption and reads as follows:

Arriving at middle age, work is excessive, and worries become harmful. There are many diseases of weakened nerves. Initially, memory becomes less clear, things are forgotten as soon as they happen. Sadness upon events (illegible), there is no telling right from left, thinking is sluggish, and one is easily aggravated. If not treated, suffering from mental illness will ensue, tinnitus, vertigo, and decline of memory will all follow. Melancholic malaise, mental and physical debility will be the end result. In past decades, Ailuo Brain tonic has received universal praise as a medicine that mind-workers shouldn’t be without. Each large bottle is 2 yuan. Small bottles are 1 yuan, 2 jiao.317

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317 *Shen Bao*. 1925 年 04 月 30 日 第 1 版 第 18736 期. “Mind worker” is a translation of 劳心 that might better be referred to as “white collar”, “brain worker”, or other such phrase. The point is that they use excessive brain power rather than physical brawn.
Figure 16: *Shen Bao* 1925年04月30日第1版第18736期

神經衰弱之良藥
人至中年，勞苦過度，或能傷人。多有神經緊張之症。初起時記憶不清，事過即忘。遇到事態*，不知進退。思慮遲鈍。容易動怒。若不即治，遂患神經病矣。耳鳴、眩暈、記憶力減退、憂鬱憔悴、身心衰弱等症。
數十年來，譽滿天下。勞心者不可不服。
艾羅補腦汁，大瓶二元，小瓶一元，二角。
*final character illegible.
Given what has been said thus far about SJSR and its gradual introduction into the Chinese lexicon, this 1925 advertisement can readily be seen as fitting into the general pattern of framing the ailment as befalling a cognitive, rather than manual, class and having a common set of symptoms as have already been described. The number of such pieces is extremely large, running often on a daily basis, month after month, until the paper ceased publication in 1949.

Stepping away from *Shen Bao* momentarily, the ubiquity of print information about SJSR in other publications can easily be demonstrated by a cursory view of the source materials collected by the Shanghai Institute of Scientific and Technological Information in their databases of the National Newspaper Index.\(^{319}\) For instance, in the years from 1900 until the proclamation of the founding of the Republic of China in 1912, there are only five articles documented that have SJSR in their title. Three of these have already been discussed above.\(^{320}\) In the first decade after the founding of the ROC, the count of such articles jumped to fifty-nine. The following decade (1930–1939) saw an increase to 329 such publications, and these numbers reflect only those articles with *shenjing shuairuo* directly in their title. In the two decades after 1912, those articles that make direct reference to *shenjing*, *shenjing guanneng*, or other such variations are almost too numerous to count, much less address in any systematic fashion.\(^{321}\) Suffice it to say that there appears to be a distinct change in the availability of discussion about SJSR that corresponds to changes in Republican-Era printing practices. Such print culture was able to naturalize and embed SJSR in the cultural lexicon by the mid-1920s.

### 3.4.3 Return to Literary Examples

In my effort to continue pointing the reader toward a shift in how Chinese people of the early twentieth century viewed their own capacity to experience conditions like SJSR (that ultimately end up being distressing for the person), we have reached the appropriate place to return to discussion of literary references to the subject. I have already explicitly argued that, as a result of his immersion in Japan, LX saw himself and a potential future Chinese populace as having

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\(^{319}\) Housed by the Shanghai Municipal Library, the second largest library in China after the National Library of China in Beijing, and currently the second largest library in the world, the Shanghai Institute of Scientific and Technological Information (上海科学技术情报研究所) has operated the National Newspaper Index (全国报刊索引) since 1995.

\(^{320}\) The first of these begins with the material cited in Section 4.1.

\(^{321}\) *Guanneng-zheng* (官能症) is the term applied to “functional disorders” as described in Chapter 2, which at least within the National Newspaper Index, do not arise as regular topics of discussion until the 1930s.
sensibilities that could serve as a counterexample to those historic Chinese people that could be characterized by an “absence of nerves”. I have also made an effort to demonstrate the manner in which the concept of “weakness of nerves” went from being completely unknown, to something known to a few Chinese like LX, to something that, by the end of the 1920s, any literate Chinese person could readily be expected to understand. The publishing capabilities, the commercial sector, and the print culture were in place to make hermeneutically possible a broad utilization of modern scientific concepts and Japanese neologisms in a manner previously unseen in China. With that said, I do not intend to continue my argument by reproducing the research efforts of others who have adequately analyzed the socio-cultural-linguistic milieu of China during this time period. Instead, I will refer to literary uses of SJSR as they have been described by others, in an effort merely to add to the preponderance of evidence suggesting that SJSR could be seen as a new possibility for a modernizing and advancing Chinese populace.

A particularly convincing argument has been made by Peng Hsiao-yen regarding how returned loanwords from modern Japanese scientific terminology profoundly modified the lexicon of modern Chinese literature as well as everyday language in speech, newspapers, textbooks, and other formats. She argues that such changes conditioned the ways that Chinese people understood their own bodies and minds, as well as those of the people around them. Peng accomplishes this in “A Traveling Disease: The ‘Malady of the Heart,’ Scientific Jargon, and Neo-Sensation”, where she uses neurasthenia as a case study showing how this “modern” disease made its way into China through Japan, having originated in the West. She begins her article by situating SJSR as a form of description for what the Chinese people were experiencing by the third decade of the twentieth century. Specifically, she says that “after the discourse of the ‘Sick man of Asia’ (dong ya bing fu) prevalent in China since the late Qing (CF. Heinrich 2008), writers in the 1920’s and 1930’s were telling us that Chinese were now suffering from the ‘malady of the heart’”. Part of her argument appears to be that, at the particular historical moment in China, people in general, and writers in

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322 Liu, Translingual Practice; Lydia He Liu, Tokens of Exchange: The Problem of Translation in Global Circulations, Post-Contemporary Interventions, (Duke University Press, 1999); James St André and Hsiao-yen Peng, eds., China and Its Others: Knowledge Transfer through Translation, 1829–2010 (Rodopi, 2012). While printing capability and print culture are not the focus of these texts, they certainly make clear that “modern” scientific concepts, often in the form of Japanese neologisms, were a unique part of the cultural landscape in early twentieth-century China. Additionally, I am not unaware of the theory-laden character of terms like “modern scientific concepts”. It is not my aim rigorously to delineate or defend what such terms mean, and they can be used pragmatically in a common sense.
particular, were at a loss for describing and naming the “sensations, feelings, psyche, and illnesses of the heart of the modern person”\(^\text{323}\). As a result, she claims “they needed to use translated vocabulary”\(^\text{324}\). Making such a claim requires that she discuss in detail some of the history of psychology as a discipline in Japan and then China, with a focus on how psychological terminology made its way into China. We saw at the beginning of this chapter that she attempted to date some of the earlier introductions of SJSR into print in China. Her claim further requires that she demonstrate incorporation of such terminology into Chinese literature and other media.

I will return briefly to the examples that Peng gives of SJSR’s use in Chinese literature. First, however, I want to draw attention generally to the possible meanings of Peng’s claim that writers and others in China “needed to use translated vocabulary”. One can see that this claim entails at least one of many possible scenarios. For example, either the existing lexicon lacked terminology that resonated with the new experiences people were having, or something more complex was occurring. An example of the former might be what happens when a person from an equatorial climate is transplanted to the north or when a person learns how to sail, both of which entail the novice having to become acquainted with a host of unfamiliar or technical jargon. The latter, more complicated scenario takes place when new experiences co-occur along with changes internal to the person. An example might be when my five-year-old daughter uses “scared” to describe feeling “embarrassed”, when someone undergoes a religious conversion, or when one navigates a socialization process in a new cultural milieu\(^\text{325}\). I think that Peng has something more like the former in mind. That is, the world had changed for the Chinese people, and as such, they needed new language to explain and describe how they were experiencing that new world. My own position is that for many, such as LX, the Chinese people were undergoing changes in their own persons that were co-occurring alongside the societal transition that typified that turbulent time. This is to recall my main argument in this chapter, part of which might be summarized by saying that Ah-Q would not have turned to a translated vocabulary had he survived into the 1930s. The change would have seemed wholly external to him. However, in time there were others for whom an alternative lexicon was necessary. Furthermore, I want merely to point out that I am not

\(^{323}\) Peng, “A Traveling Disease,” 144.
\(^{324}\) Ibid., 114.
\(^{325}\) Regarding undergoing socialization, this might be going to medical school or joining the armed forces, for example. However, I think the clearer example is being immersed in another society and language. Religious conversion is a clear example as well.
convinced that the Chinese needed to use translated vocabulary; I am content to recognize that they did, in fact, use translated vocabulary.\(^{326}\)

Transitioning back to Peng’s references to the early modern Chinese literary scene, she makes the claim that neurasthenia had entered broad conceptual employ and was referenced by Chinese authors as they attempted to understand themselves and their time. As I have already mentioned, SJSR appears famously in LX’s diary but only in passing a few times in his other works. As one example of SJSR being put to use as a translated vocabulary, Peng points readers in the direction of some of the writers that made up the New Sensationalist movement.\(^{327}\) One of the founders of the movement, Liu Na’ou, (劉吶鵷, 1905–1940) described his own struggles with the ailment in his diary in 1927, some fifteen years after LX. However, according to Peng, as an explicit category of experience, “the term neurasthenia appeared in modern Chinese literature around the mid-1920s”.\(^{328}\) By that time, it could be referenced in a manner that took for granted that readers understood what the term meant. Peng relies on this fact as a central feature of her thesis, with Mu Shiying’s short story, “A Man Taken as a Plaything” serving as the starting point for her discussion of neurasthenia.\(^{329}\) Her position, in short, is that Mu Shiying took a lighthearted or, perhaps, satirical view of other writers’ use of contemporary scientific and psychological vocabulary in their literary works. The main targets of this satire, she argues, were the various novelists that made up the Creation Society.\(^{330}\) Translated terms like neurasthenia, hypochondria,

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\(^{326}\) After all, the Chinese could have done something like what the Japanese did; namely, they could have drawn on their own textual tradition and created neologisms from there. Of course, this was already done.

\(^{327}\) The New Sensationalist Movement (xin ganjue pai, 新感觉派) was a group of writers that focused more on the psychological and aesthetic experiences of modern Chinese, in stark contrast with the deeply political and revolutionary writings of some of their contemporaries that arose after the May Fourth Movement. Mu Shiying, Liu Na’ou, and Shi Zhecun were the main authors. For further discussion see Leo Ou-Fan Lee, Shanghai Modern, 190–231.

\(^{328}\) Peng, “A Traveling Disease,” 113.

\(^{329}\) Mu Shiying (穆時英, 1912–1940) is well known for his short stories as well as for being a major figure/founder of what is known as the “new sensationalist movement” (新感觉派). His short story mentioned here has the Chinese title, “被当作消遣品的男子”.

\(^{330}\) It is not my aim to discuss the history or other intricate details of these literary societies and their productions. That has been done in Denton and Hockx, 2008 and others. However, I will mention briefly that the Creation Society or Chuangzao she (創造社) was a literary society that owed its existence to several Chinese intellectuals who had studied in Japan and used the vernacular language of baihua (白话) while incorporating contemporary terminology provided by the translated vocabulary of psychological sciences to describe the social and psychological milieu of the China of the day. Guo Muoro (郭沫若, 1892–1978), Zhang Ziping (张资平, 1893–1959), Cheng Fangwu (成仿吾, 1897–1984), and Yu Dafu (郁达夫, 1896–1945) were the figureheads of the Creation Quarterly (创造季刊) literary journal, which had its debut in Beijing in 1922.
and hysteria (xie si di li, 歇斯底里) made frequent appearance in Creation Society writings and
were taken as matters of fact in the contemporary Chinese situation of the day. Specifically, she
references Zhang Ziping’s 1926 novel Taili (苔莉) wherein the protagonist says of his cousin’s
wife, with whom he had an affair, “She fell ill with hysteria, while I, with neurasthenia”. In like
manner, Yu Danu’s most famous novella, Sinking (沉沦), deals with the plight of a young Chinese
student living in Japan who suffers from “hypochondria” and “megalomania”. Both terms were
printed in English in the original, with the Chinese youyuzheng (忧郁症) offered as a footnote. An
inveterate masturbator and frequenter of Japanese geisha houses, the protagonist of Sinking
hates the Japanese women he desires because he believes they look down on him for his Chinese-
ness. His apparent suicide in the Sea of Japan is accompanied by his famous call for China to grow
stronger, blaming his death on the nation’s weakness: “O China, my China, you are the cause of
my death! . . . I wish you could become rich and strong soon! . . . Many, many of your children
are still suffering”. Peng makes reference to Sinking and then immediately cites the famous author, professor,
and Catholic convert Su Xuelin (1897–1999) who is well known for her criticisms of the decadence
and self-absorption of her contemporaries, like LX and Yu Dafu. In 1934 she wrote that “Egotism”,
“Sentimentalism”, and erotic indulgence constituted the basic elements of Yu’s works.  

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331 Peng, 113. Hysteria is xie si di li, (歇斯底里), while neurasthenia is the term SIJR.
332 For the reader of Japanese, this term is yuu-utsu shou (憂鬱症), or severe depression. However, it should be
clear that this category of illness is not necessarily conceptually related to “hypochondria” at all. This is a matter of
rather complicated inquiry, which I have taken up personally but is beyond the scope of the present discussion. In short, I believe that Yu Dafu was suggesting something with his use of “hypochondria” that is not addressed in any
commentaries on his story; namely, that the perceived deficiencies of the protagonist were believed but not based
in reality. As such, the Chinese sense of inferiority that is expressed by the protagonist is one that is imagined,
without basis in fact. That is to say, the illness that caused his suspected suicide was hypochondriacal self-loathing.
His outlook regarding himself and how others saw him was not an accurate representation of reality. He was
melancholic and delusional as a result. Delusional self-degradation was the norm in his day for Chinese people
comparing themselves to the world (consider Smith’s view of them). Unfortunately, we cannot pursue this further.
333 Joseph S. M. Lau and Howard Goldblatt, The Columbia Anthology of Modern Chinese Literature (Columbia
University Press, 2007), 55. The original Chinese text is as follows: 「你快奮起來！強起來罷！你還有許多兒女在那裡受苦呢！」
334 陈子善 and 王自立, 部落夫研究資料 (三聯書店香港分店, 1986), 68. In the original, egotism and
sentimentalism are used in English, with the Chinese stated as 自我主义 and 伤感主义. I have translated “erotic
indulgence” from Su’s use of the term 風流放逸, for which she offers no English translation. This is perhaps
because 風流放逸 she pulls from an existing Chinese tradition, for which she need not draw from any translated
concept or vocabulary. This is basically Peng’s point; namely, that there are certain ideas that need to draw on a
Interestingly, when writing specifically on *Sinking*, Su interprets the protagonist’s plight as going beyond hypochondria, megalomania, or depression (忧郁病). In fact, she says of the protagonist that, “because he is unable to curb his erotic appetites, he becomes self-destructive, all vitality sinking into a neurasthenia, the result is suicide by throwing himself into the sea”. Despite the fact that Yu Dafu never made reference to SJSR in that particular work, Su interprets his specific malady as a contemporary phenomenon subsumed within the modern, translated conceptual category of SJSR. For Peng, this is an instance of the need for a translated vocabulary to get at the contemporary lived experience. While I agree with this, I want simply to go a step further by suggesting that Su’s application of SJSR to the protagonist further illustrates that, by the time of her writing (1934), SJSR was comfortably embedded in the Chinese lexicon.

Mu Shiyiing, however, does make explicit reference to SJSR in “A Man Taken as a Plaything”. The protagonist claims that he has developed SJSR as a consequence of his pursuit of the modern Shanghai girl. The nature of this relationship entails all the complications of Shanghai nightlife such as dance halls, jazz, imported American pastimes and references, and multiple suitors who are competitors for the narrator and additional playthings for the girl. On four separate occasions in the story, the narrator endorses his having fallen victim to neurasthenia. He blames her specifically by stating, “she cured me of misogyny, but gave me neurasthenia”, and later goes on to bemoan the fact by claiming, “I feel that I’m suffering from profound neurasthenia”. Peng’s interpretation of this use of language is that whenever “psychological jargon becomes the target of ridicule in a literary work, we are looking at the vernacularization, or popularization, of the knowledge imbedded in psychology as a discipline”. To be more precise, she believes that Mu Shiyiing’s use of SJSR to describe such ephemeral and banal goings-on satirizes the more serious and polemical postures of his contemporaries. My own view is that, at the very least, it further demonstrates the entrenchment of SJSR as an available conceptual category by this time in China’s history.

translated vocabulary, while other ideas have perfectly resonant and living terminology that adequately capture the phenomenology of a given experience.

335 陳 and 王, 鄭達夫研究資料, 74: “里主人公为了不能遏制情欲,自加戕戮, 至于元气销沉神经衰弱,结果投海自杀.”
336 穆時英 and 賈植芳, 穆時英小說全編 (學林出版社, 1997), 105,110. The Chinese text reads, “她一医愈了我的女性嫌恶症,你又送了我神经衰弱症” and “我觉得自己是患着很深的神经衰弱症” respectively.
3.5 Conclusion

It has been my overall aim in this chapter to provide some background so that the reader might be able to consider how the content from Chapter 2 became relevant for the Chinese people. However, the Chinese did not pass through a gradual, historical acclimation to the complex discourse of nerves, which lasted nearly two centuries in the Euro-American context. I have tried to describe some of the ways in which there was a shift in how Chinese people of the early twentieth century viewed their own capacity to experience and describe distress, which found a form of manifestation in what became known as SJSR. Part of this process has included a discussion of neurasthenia in Japan and some of the ways it was interpreted there. I argued that, early in the twentieth century, intellectuals like LX, who were introduced to SJSR through Japan, considered the ailment to be something that would not befall simply anyone, as those Chinese people who were represented by figures like Ah-Q did not yet have the susceptibility and sensitivity of constitution that made the disease possible. LX, in the person of his narrator, was a representative exception. With the founding of the Republic and efforts to import new knowledge and sophistication into the culture, new means of information distribution arose in the forms of magazines, gazettes, and newspapers. In time, the development of large commercial publishing companies with modern mechanical printing presses, daily exposed any willing reader or commercial consumer to articles and advertisements, slowly embedding SJSR in the popular lexicon. Through print media, including fiction of the day, the neurasthenic condition became a viable category of experience that anyone could understand. By the 1930s the Chinese populace went from being members of the “sick man of Asia” exemplified by Ah-Q, to being something else entirely. Ironically, to move beyond that “sickness”, the Chinese began to see themselves as capable of a different kind of sickness. The weakness of nerves became something that demonstrated China’s advancement toward equality with the Japanese, the Americans, and the Europeans. It was part of becoming modern.

China went from a state of affairs where nobody knew about SJSR to a situation where almost anyone could describe a given experience as being precisely an instance of SJSR. As I mentioned in the previous chapter, for the Chinese there was no previously existing discourse of nerves or nervousness on which SJSR could build. When a change of this nature takes place within any social milieu, it raises interesting questions about the type of cultural work to which the newly introduced and rapidly entrenching category can be put. In other words, once the category becomes
a part of the lexicon, how might it be put to use? As a concluding line of thought I want to return to Howard Shapiro’s work on hospitals in early Republican China in order to look at one issue he raises in passing. I think his question highlights the possibility of an analogous process that is at the heart of the present project.

Shapiro’s research uncovered evidence in from Beijing Union Hospital medical records of the influence of literature and the arts on some early Republican-Era patients. 338 For instance, he describes how one patient escaped criminal charges by eating his own excrement, a method of feigning madness that he claimed to have learned from Song Jiang in *Outlaws of the Marsh (Shui hu zhuan).* 339 Similar phenomena were documented by others; in his sociological study of 1920s Beijing, David Strand recounts how rickshaw pullers expressed their ideas using language and examples taken from the “operatic stage”. 340 Shapiro argues that opera provided motifs of bodily expression used by women to feign madness and seek refuge from familial situations. He recounts another case where physician records describe a patient singing in a high-pitched voice while performing operatic hand gestures, only later explaining that she was trying to find a way out of her situation at home by being admitted to the hospital. Shapiro suggests that the prescribed hand and sleeve movements of the theatre served as a vocabulary for articulating illness. Such gestures are briefly discussed in A.C. Scott’s *The Classical Theatre of China,* wherein he explains the idiomatic movements used to “signify someone not responsible for their actions or madness”. 341 The point here is that, if watching performances like Mei Langfang’s depiction of Miss Zhao’s “mad scene” in *Yu Zhou Feng* could serve patients’ goals of feigning madness, then serious questions arise about how other conceptual categories get put to use. 342 Shapiro asks, “did women consciously, or unconsciously, emulate motifs preformed on the stage?” 343 He concludes by raising the issue that I find at the heart of all nosological constructions of illness categories. He states:

338 Shapiro, “The View from a Chinese Asylum.”
339 The Chinese title of the classic work is 水浒传.
341 A.C. Scott, *The Classical Theatre of China* (Allen & Unwin, 1957), 99. He writes, “Pai hsiu: The end of one sleeve is held at waist height with the other hand and the arms are quickly swept right and left. It signifies someone not responsible for their actions or madness”.
343 Shapiro, “The View from a Chinese Asylum,” 181.
This raises a critical problem of interpretation: was the ‘craziness’ of the stage mindfully emulated? Or instead, did the examples from vernacular literature condition the experience of madness? In other words, was the madness of women a conscious emulation of social templates or a culturally-conditioned expression of mental illness? These issues refer us back to the elusive question of how cultural knowledge is embodied as disease.\(^{344}\)

What is of interest here is not the universal phenomenon of malingering or feigning illness for some other purpose. Rather, we can consider the possibility that patients who were truly ill manifested their illness through forms that were socially and culturally available, forms which are contingencies of history, cultural belief, practice, and geography. Illness in a Chinese literary and cultural context seems to be intimately related to an aesthetics of illness, a historical sociology of national situation, and a medical anthropology of illness. The role of illness representations in Chinese print history has served not only as a canonical means for expressing idealized aesthetic fetishes in texts like *Dream of the Red Chamber*, for example, but it has carried over into metonymic signification for a pathologized nation and ethnic zeitgeist in writers like LX and Yu Dafu.\(^{345}\) I believe that the most interesting case of all, however, is the under-studied situation whereby the introduction of conceptual categories of diagnosis like SJSR contributed to the cultural knowledge of how experiences of certain types of distress are likely to manifest and how the sick role can or is supposed to be carried out. In the past, spitting blood seems to have been one idiom of extreme distress that was universally understood, if not attempted.\(^{346}\) One of the purposes of this project is to press the notion that local categories serve as paradigms that can become embodied and manifested as signifiers of extreme distress.

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\(^{344}\) Ibid., 190.

\(^{345}\) I am thinking of the well known example of *红楼梦* in the former case, LX’s Ah-Q and Yu Dafu’s *Sinking* in the latter cases.

\(^{346}\) This occurs numerous time in *红楼梦* and other texts, too numerous to recount here. For some background on these issues in that famous Chinese text, see: Andrew Schonebaum, “Medicine in The Story of the Stone: Four Cases,” in *Approaches to Teaching The Story of the Stone (Dream of the Red Chamber)*, edited by Andrew Schonebaum and Tina Lu, 164–85 (Modern Language Association of America, 2012); Andrew Schonebaum, “Vectors of Contagion and Tuberculosis in Modern Chinese Literature,” *Modern Chinese Literature and Culture* 23, no. 1 (2011): 17–46.
Chapter 4: Western Psychiatry Engages Shenjing Shuairuo

“The ideas we export to other cultures often have at their heart a particularly American brand of hyper-introspection and hyper-individualism. These beliefs remain deeply influenced by the Cartesian split between the mind and the body, the Freudian duality between the conscious and unconscious.”

Thus far we have examined the historical origins behind the label neurasthenia, and we have had some discussion of its introduction to and acceptance as a category of experience in Japan and China. The current chapter picks up with the first serious engagement between Western academic psychiatry and the formal diagnostic category of SJSR as it was used in Taiwan and China after the close of the Cultural Revolution. While in Taiwan the DSM and the ICD were officially used, China developed its own system of classification. The first drafts of the Chinese Classification of Mental Disorders (CCMD) appear to have begun in the 1950s, coinciding with the first nationwide conference on psychiatric disorders in 1958. A second national conference in 1978 led to the convening of a committee that revised the 1958 draft and produced the 1979 “Draft of Classification of Mental Disorders”, which was to constitute the first edition of the CCMD (CCMD-I). This edition coincided roughly with the World Health Organization’s adoption of the ninth edition of the ICD. As a result of the publication of material presented in this chapter and the publication of DSM-III (1980), work on the CCMD continued in 1981, 1984, and 1986. SJSR was ultimately retained as a diagnostic category, but debates have been ongoing ever since American psychiatrists first challenged its validity in the publications addressed in the following pages.

Studies of phenomena properly belonging to the field of cultural-psychiatry were undertaken long before Chinese SJSR became a subject of intense scrutiny. For instance, Yap tackled the matter of what would later be called “culture-bound syndromes” as early as 1951. There are many other such studies but these are not my focus. My concern is solely with SJSR,

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347 Watters, Crazy like Us, 254.
which entered the debate some twenty years later as a result primarily of Arthur Kleinman’s work in the late 1970s and early 1980s. It is to his credit that anthropology and psychiatry have focused their lenses on this fascinating form of human experience. Most writing on neurasthenia and SJSR, especially writing from the perspective of the humanities, cites new cross-cultural psychiatry (NCCP) literature from the 1980s as an affirmative model for understanding SJSR; I take a different approach. I view the NCCP model of SJSR from that period as an imposition of the diagnostic framework of Western psychiatry of the day. I will not address the various theoretical debates in cultural psychiatry. I am interested specifically in the stance taken regarding Chinese SJSR, which involves precise claims about Chinese culture and language that have not been retracted thirty-five years later.

Kleinman’s earliest publications did not address SJSR as a specific and theoretical topic of inquiry as he was, at that time, heavily focused on comparative health systems and comparative systems of medical meaning.\(^\text{350}\) Even so, as early as 1975, he already had some established opinions regarding the diagnosis of certain Chinese patients whose presentations carried specific cultural features. For instance, in the *American Journal of Chinese Medicine* he offered a brief case discussion of a thirty-year-old man with insomnia, weight and appetite loss, fatigability, chronic pain in the neck, and loss of interest in work and life activities who denied being depressed or feeling dysphoric. Mr. Wang attributed his experience to a loss of *qi*. After failing some herbal and acupuncture treatments, he tried three weeks of antidepressant medications. It was said that thereafter he had complete symptom relief. Kleinman reported being “convinced that this was an empirical demonstration both of the efficacy of the antidepressant and of the diagnosis of depression”.\(^\text{351}\) Relating this to Chinese culture and its “tremendous impact on symptom formation”, he stated that a “number of dysphoric affects, usually presented as psychological


complaints in Western cultures, are presented as somatic complaints by Chinese patients; this process of somatization . . . seems to have specific characteristics in Chinese populations”. I return to this case shortly, but it should be pointed out that these conclusions are of interest for a few reasons. First, even in 2017 there is still a great deal of research aimed at elucidating precisely to what the clinical label “depression” refers. Second, antidepressants are helpful across a variety of complaints for which patients see a physician; improvement does not indicate the etiology of the initiating complaint. Third, the claims regarding somatization remain to be carefully examined. While I do not address each of these problems specifically, they should all be kept in mind when considering the various views of SJSR as they arise throughout this chapter. I aim to demonstrate that, from the very first encounters with Chinese SJSR patients, the engagement gave a privileged place to Western diagnostic systems and was framed by a process of re-diagnosis and re-definition.

In this chapter, it is also my aim thoroughly to address the interpretations of SJSR that took hold in the literature of NCCP during the 1980s, which interpretations are nascent in Kleinman’s case discussion cited above. The models of Chinese experience of SJSR developed over a number of years and had consequences for the research programs and literatures that followed. There were also Chinese academic responses to the predominant NCCP models that resisted Western psychiatry’s theoretical formulations, although they seem not to have achieved much traction in the English language literature. Tracing these developments in thought requires an approach that focuses on the major, groundbreaking publications and claims that have proven so influential, even to the extent that alternative interpretations have been difficult to achieve as the study of SJSR has

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352 Ibid., 115, 117. In the twentieth century, we have seen “socialism with Chinese characteristics”, “somatization with Chinese characteristics”, and “capitalism with Chinese characteristics”.

353 Addressing that literature is beyond the scope of this writing. Unfortunately, whatever is learned about the concept of depression and its etiologies and mechanisms, the term itself is theory-laden and is unlikely to be changed. The possibility that those illnesses labeled as depression may actually constitute a set of heterogeneous phenomena, should be the topic of intense research.

354 For example, the suffering that occurs from opiate withdrawal will improve with heroin, but that does not mean that the patient suffers from a deficiency of opioids. In like manner, blocking serotonin and norepinephrine transporters with tricyclic antidepressants will increase those neurotransmitters at synapses, but it does not logically follow that the positive change reported by the patient in any sense demonstrates that they had a deficiency of the neurotransmitters. The fact that a drug makes us feel better is limited in what it tells us about the patient. Sometimes it tells us a great deal, however. The efficacy of anti-retroviral medications serves as a strong argument that retro-viruses are responsible for AIDS. Such information tells us what to look for, but it does not prove the case. That requires isolation of the virus, which has now been done.
continued into the twenty-first century. Alternative stances in the American and Chinese literatures are also considered, and I undertake the task in the following manner.

The material as a whole is organized in a chronological fashion. I begin with what I think is an uncontested starting point for NCCP interpretations of SJSR: Kleinman’s 1977 paper “Depression, Somatization and the ‘New Cross-Cultural Psychiatry’”. The first section of the current chapter establishes a hermeneutic framework for reading the subsequent work of Kleinman and others. In section two, I examine what is probably the most influential monograph regarding SJSR, a monograph that established Kleinman’s original model of somatization. There I demonstrate that his model relied on some very dubious claims regarding Chinese culture. In Section 3, there are several papers that employ Kleinman’s work as a theoretical ground for viewing somatization in a number of patient populations and contexts. Section 4 is a discussion of Kleinman’s study of neurasthenia patients in Hunan, China, which took place in 1980 and was originally published as a report in 1982. The report was later re-fashioned into a monograph in 1986, but not before it received reactions in both American and Chinese literatures. Section 5 pertains to the edited volume of 1985, Culture and Depression, which followed Kleinman’s Chinese publication “Somatization” in Guowai Yixue. I suggest that, by the time of the publication of these works, his model of SJSR as somatized depression was beginning to lose the coherence it had in 1980 while at the same time becoming a less derogatory position. Section 6 is a short overview of the 1989 special edition of Culture, Medicine and Psychiatry on the subject of neurasthenia. Some of the Chinese authors in that edition took issue with Kleinman’s model, and these authors are briefly discussed, along with relevant commentary by Xu Youxin, professor and director of the Peking University Institute of Mental Health. Section 7 briefly refers to the 1988 monograph, Rethinking Psychiatry, which addresses SJSR indirectly. I conclude with a summary of what the chapter has intended to show.

4.1 The Late 1970s and the “New Cross-Cultural Psychiatry”

A reasonable candidate for the beginnings of NCCP is one particular critical response to the transcultural psychiatry in place during the mid-twentieth century. As a starting place, I draw attention to a researcher in the psychiatry department at the University of Hong Kong, Kieran Singer, who in his 1975 paper titled “Depressive Disorders From A Transcultural Perspective”, made a very thorough attempt to get at universally valid definitions for depressive disorders. After
looking carefully at a large number of epidemiological studies, Singer concluded that “investigations to date on the role of culture in depressive disorders have been unsophisticated. There is insufficient evidence to support the prevalent view that depressive illness in primitive and certain other non-Western cultures has outstanding deviant features”. Singer’s goal appears to be that of finding transcultural similarities in symptom manifestation, and his conclusion leaned toward the view that depressive illness was more similar across cultures than it was different. He did recognize, however, that there appeared to be differences among people in “the Orient”, as he clearly stated that “it is possible . . . that cultural beliefs which inculcate an unhealthy preoccupation with the functions of the body, as traditionally found in the Orient, play a pathoplastic role in the genesis of these symptoms”. His final comment is a word of caution: “it would be unwise to embark on further comparative work without closer attention to the problems of methodology. Alternatively, researchers may perhaps be more fruitfully occupied testing hypotheses about the nature, distribution, and consequences of depressive disorders in their own cultures”.

Singer’s paper served as a springboard for Kleinman’s announcement of the shift away from the “old transcultural psychiatry” to the new cross-cultural psychiatry. In 1977 Kleinman wrote a critical response to Singer’s analysis, rejecting the idea that “the features of depressive disorders do not exhibit significant cross-cultural differences”. On the contrary, he argued that such differences did exist and were a result of the cultural shaping of normative and deviant behavior. To demonstrate his contention, he relied on qualitative data from his work with Chinese patients, stating that “somatization amongst Chinese depressives is used as an illustration”. Before commenting on these cross-cultural differences and their supporting data, it is helpful to recognize Kleinman’s main criticism, which is that Singer committed a “category fallacy”. As

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355 K. Singer, “Depressive Disorders from a Transcultural Perspective,” *Social Science & Medicine* (1967) 9, no. 6 (June 1, 1975): 297, https://doi.org/10.1016/0037-7856(75)90001-3. “Outstanding deviant features” is an unfortunate choice of wording. What he intended was that clinical depression in those other cultures appears to fail to demonstrate symptomatology that deviates significantly from those that Western researchers expected.

356 Ibid.

357 Ibid., 298


359 Ibid.
mentioned above, both this criticism and the supporting data serve as a framework for reading subsequent sections of this chapter.

My purpose is not to rehash an old debate between two scholars, so I do not address whether Singer really is guilty of the error for which he was accused. However, it is important to understand what such an error would look like. Kleinman formulated a very important hermeneutic and methodological problem that potentially lurks in all cultural research, and serves as the major issue to be recalled throughout the remainder of the current project. He termed it a “category fallacy”. That is to say that the researcher might “dispense with indigenous illness categories because they are culture-specific, [and] go on to superimpose their own cultural categories on some sample of deviant behavior in other cultures, as if their own illness categories were culture-free”.

This is a very important and reflective consideration that has extreme relevance today as psychiatry, led by academic and pharmaceutical efforts centered in Europe and the USA, continues to engage populations across the globe. Perhaps Kleinman’s greatest contribution has been in pointing out that transcultural psychiatry tended toward “reliance on external, Western psychiatric categories which are applied by clinicians and epidemiologists as if they were independent of cultural bias”. If this criticism rightly applies to Singer’s work, it is probably the result of methodologically limiting comparative studies to those phenomena that are obviously related to the categoric phenomena of his interest, overlooking phenomena that problematized his ideas because these are culturally specific in either form or content. With this contention of Kleinman’s in mind, I want to consider what he sees as counter-examples to Singer’s claim that depression does not essentially vary across cultures.

As is clear from the title of this pivotal paper, Kleinman centered his discussion on “depression and somatization in Chinese culture”. It is beyond the aim of the current section to address all the individual claims about Chinese understandings of mental illness that are made in

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360 The debate between Kleinman and Singer was severe enough that Kleinman intimated that Singer’s view approached a “veterinary perspective, the antithesis of a cultural study”. K. Singer, “A Comment,” *Social Science & Medicine* (1967) 11, no. 1 (January 1, 1977): 11–12, https://doi.org/10.1016/0037-7856(77)90139-1. Singer responded to Kleinman’s criticism and was met with this rather demeaning comment by Kleinman in return.


362 Ibid. Of course, this is still going on as researchers continue to study “depression”, “schizophrenia” and other disorders as though they were universally invariable and homogeneous entities.

363 I remind the reader that Singer may not actually have held such a view, but he was interpreted as having such a position.
this paper. However, it is vital to address two claims that run through all or most of Kleinman’s publications on depression and SJSR in China and Taiwan. The first claim is that “popular labels [in Chinese] for mental illness cover only indisputably psychotic behavior and mental retardation. Minor psychiatric problems like depression, anxiety reaction, hysteria, psychophysiological reactions, etc.—most commonly are labeled as medical illnesses . . . [P]sychological issues are systematically left unlabeled”. This mistaken assumption about the availability of labels and linguistic tools for describing psychological issues appears to be one of the presuppositions that informs Kleinman’s model of somatization. While recognizing the use of some terms like *men* (門), among others, discussion is limited to terms encountered in interactions with patients. One wonders if there is an implicit claim being made about the need to express symptoms bodily because patients lack the linguistic tools to describe their experiences in psychological language. Other reasons offered as explanations for Chinese patients’ somatic complaints are more explicit.

The second claim, and the fundamental presupposition of the 1975 paper, is that Chinese patients with mental disorders tend to present somatic complaints in place of psychological ones. While Kleinman admits that somatization exists in the USA, it is believed to occur more frequently among Chinese patients. Some reasons are given for why this might be so. First, mental illnesses are more stigmatizing for Chinese and can label an individual or a family, causing many difficulties in social life, including calling into question fitness for marriage. Second, medical sick roles are socially sanctioned, whereas psychiatric sick roles historically have not been; therefore, sick roles release the sufferer from certain obligations. He cites SJSR as the most common medical sick role available for Chinese patients with mental health concerns, although SJSR has not become the systematic subject of his research yet. Third, it is claimed that Chinese informants and patients “do not commonly reveal strong normal or dysphoric affects . . . [S]uppression of affect is common”.

These cultural considerations are offered as an account for differing phenomenologies of

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364 Ibid., 6. This is addressed in discussion of Leff below.
365 Much attention is paid to terms like *huoqi da* (火氣大) and *suan* (酸) in both this paper and other writings, with the implication that there is some deeper theoretical model of symptoms at play in their use. While this may be the case with some terms, those like *huoqi da* seem colloquially unimportant, especially when considering that terms like *Shengqi* (生氣) also sound like they imply some classical model of physiology (and sometimes disease) but are never really intended that way. Certainly, such terms are not employed as substitutions for psychological terms. They are psychological terms in their own right. *Shengqi* is to be angry; it is not some somatic diversionary tactic to avoid acknowledging one’s emotional state.
366 Ibid., 5. Clear definitions of “somatization” will develop as this chapter progresses.
367 Ibid., 6. This idea of the suppression of affect occurs in the next section.
depressive illness among American and Chinese patients; having outlined these explanations, Kleinman turns to three brief case descriptions to exemplify such phenomenologies.

Three cases are offered: Miss Liu is a thirty-two-year-old Taiwanese accountant, Mr. Hung is a sixty-year-old retired Navy Captain from China and living on Taiwan, and Mr. W is a thirty-three-year-old Chinese male (Cantonese speaking) who presents at the medical clinic in Boston. I do not address Miss Liu or Mr. Hung, but briefly discuss Mr. W, who alone is not given a name but is rather indicated only by a letter. I focus on Mr. W only because he serves to illustrate that the conclusions in this 1977 paper are not new, and we already know something about his case. As can be seen from Table 1, Mr. W is the same person as Mr. Wang in the 1975 paper mentioned at the beginning of this chapter.

Table 1: Comparison of patients from 1975 and 1977 papers on somatization. Similarities in bold.

<table>
<thead>
<tr>
<th>Person</th>
<th>Age</th>
<th>Symptoms</th>
<th>Patient’s view of illness</th>
<th>Recent history</th>
<th>Self-treatment</th>
<th>Medical Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr. Wang</td>
<td>30 yr. Chinese male</td>
<td>- insomnia, - anorexia, -20 lb. wt loss, -chronic pain in cervical spine, -heaviness in both feet for 6 months, -easy fatigability, -loss of interest in work and life activities</td>
<td>“wind” disease, (fung)*</td>
<td>Recent business failures, Several miscarriages preventing wife from child-bearing.</td>
<td>One trip to Hong Kong for herbal and acupuncture.</td>
<td>Course of antidepressants, Complete Symptom relief.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Patient stated: “antidepressants may be effective against ‘wind’ disease”.</td>
</tr>
<tr>
<td>Mr. W</td>
<td>33 yr. Chinese male indicated as Cantonese speaking</td>
<td>- insomnia for 6 months -20 lb. wt loss, -pains in upper back described as rheumatism, -heaviness in the feet, -Tiredness, -dizziness, -general weakness,</td>
<td>Due to “wind” (fung) * - “not enough blood” (m-kuai huet) * from over indulging in sex with prostitutes, causing him to suffer “cold” (leung) *</td>
<td>Lost most of his savings in the stock market, Wife had second miscarriage, no current children</td>
<td>Friends suggested trip to Hong Kong for treatment.</td>
<td>Use of Herbs/Tonics</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Patient stated: “antidepressants perhaps were effective against ‘wind’ disorders”.</td>
</tr>
</tbody>
</table>

Note: being from Honk Kong, both patients should be Cantonese speakers. Yet Mr. Wang’s explanation of illness is given in mandarin Pinyin, while Mr. W is quoted in Jyutping.

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A few features of these cases should be of interest. First, they are clearly the same patient. The age and time in the USA correspond with the year published, among the other overwhelming indicators. However, they are presented as though they are different persons. When responding to Singer’s work from the University of Hong Kong, Mr. W is clearly offered as a Cantonese speaker with a more elaborate model of his own illness involving blood deficiency; the earlier case appears to be a patient whose illness model is given from the perspective of a Mandarin speaker (from the pinyin quotations) who fails to mention anything about blood deficiency. Second, and related to the first, a long-existing tension surfaces regarding the reliability of qualitative data in research of this kind. It is not my aim to stress this tension any further. I leave it up to the reader to decide what implications should be drawn from the discrepancies here. For the sake of argument, we might assume that this is a mistake easily made when dealing with qualitative data, rather than assume that it is an intentional alteration of data. It does raise the question, however, why it is necessary to re-use qualitative/case description data of this kind when there is presumably no shortage of cases available to demonstrate the point.

These cases suggest that this view of SJSR, outlined in detail throughout the following pages, was almost completely formulated very early, before the research attributed as the source for bringing NCCP interpretations to a wider audience and before the publication that introduces my second section, which relied on fieldwork from the mid-to-late 1970s. As early as 1975, Kleinman had come to three conclusions: 1) Chinese tend to present with somatic complaints more than their Western counterparts; 2) “indigenous Chinese cultural categories pattern the perception and experience of depression”\(^\text{369}\); and 3) the ailments that Chinese patients present with constitute somatizations that they fail to recognize as, and deny being examples of, depression.

Throughout his research, Kleinman does not simply dispense with indigenous Chinese cultural categories methodologically. Where other authors may have been dismissive of indigenous models of illness, Kleinman takes them very seriously and attempts to study them. One manner of approaching these categories is by differentiating a disease concept from a cultural category that constructs illness experience, as we will see in the next section. However, I contend that he violates his own standard of the category fallacy in another manner. He indirectly dispenses with indigenous categories when he reduces them to Western categories; in other words, he

undertakes a philosophically reductionistic stance by categorizing the patient experience as “somatization” and labeling them “depressives”. The epidemiologists and transcultural psychiatrists may have methodologically ignored “wind” disease, “blood deficiency”, and “neurasthenia” in their investigation of depressive illness, insisting on the diagnostic criteria for depression from their own cultural perspective. But, while Kleinman does include those Chinese categories, he reduces them ontologically to the category of depression, which category he inherits from his own culture and training. This category fallacy via reductionism plays out in the subsequent research that focuses particularly on Chinese experiences of SJSR.

4.2 Patients and Healers: Cross-Cultural Psychiatry of SJSR in Taiwan

Kleinman’s work began in earnest as a psychiatry resident from 1972–1975, the time during which he developed the conclusions seen in the previous section. Of his works that take up SJSR specifically, the most influential was published in 1980, the year neurasthenia was removed from the DSM. I refer to this first major work as Patients and Healers. At the time, Kleinman was continuing his research on health care systems across cultures with the aim of developing a theoretical approach to understanding “how culture affects core clinical activities and in what ways they constrain the cultural patterning of health care”. To accomplish this he employed ethnographic research carried out at general medical clinics in Taiwan in 1975, and similar qualitative data from 1974 in Boston. He focused primarily on three issues: illness experience, practitioner-patient transactions, and the healing process. The theoretical questions he poses in his “Orientations 1” are numerous, but for the purposes of the present work it is worth mentioning just three: “What are the range of clinical phenomena in a society? How do they relate to systems of cultural meanings and norms on the one hand and to institutionalized social patterns of power relations on the other? How and to what extent do cultural conceptions about sickness influence the prevalence, morphology, and course of particular disorders?”

This third question is the fundamental question at hand, especially as it relates to morphology. In particular, I am interested in the conclusions regarding SJSR as they pertain to this

371 Ibid.
372 Ibid., 18–19. The first question cannot be answered because there is no boundary condition. The second is a fascinating question that is beyond our inquiry, but it is related to the central, and third, question.
third question. To understand how he conceptualizes the phenomenon and accounts for its cultural particularity, it is necessary first to make clear his theoretical distinction between disease and illness.

The key framework for understanding Kleinman’s initial model of SJSR is the illness/disease category distinction, which he delineates in “Orientations 3: core clinical functions of a health care system, cultural construction of illness as psychosocial experience”. The first of five core clinical functions is where we find what he calls an “analytical dichotomy” between disease and illness. Disease is the term reserved for a particular type of explanatory model that describes biological or psychological malfunctioning. Most often employed by the professional practitioner, this model refers to a particular type of process or relationship that takes as its focus “biochemical processes, anatomical structures, physiological reactions, or patterns of behavior and communication”. Illness, on the other hand, describes the experience of the patient (and perhaps those close to the patient), including its meaning for the patient, responses to the experience, beliefs about the ailment, cognitions, and values regarding the experience. In other words, illness describes the varieties of experience that arise out of being sick, along with its personal, social, and cultural meanings. In some places, he refers to this distinction as “two aspects of sickness”, at other times elaborating that “disease/illness can be thought of as expressing different aspects of a single clinical reality, or representing different aspects of a plural clinical reality, or creating different clinical realities”. There are a number of theoretical problems with the disease/illness dichotomy that simply cannot be addressed here due to space limitation. Instead, it is more helpful to move directly to how this approach becomes applicable for characterizing SJSR.

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[^373]: Ibid., 71. The five core clinical functions are as follows: “1.) The cultural construction of illness as psychosocial experience. 2.) The establishment of general criteria to guide the health care seeking process and to evaluate treatment approaches that exist prior to and independent of individual episodes of sickness. 3.) The management of particular illness episodes through communicative operations of labeling and explaining. 4.) Healing activities per se . . . 5.) The management of therapeutic outcomes . . .” Emphasis in original.

[^374]: Ibid., 73.

[^375]: Ibid., 73–74

[^376]: For example, the dichotomy requires a clear stance regarding whether illness is or is not the “shaping of disease into behavior and experience” as Kleinman also claims on page 72. If so, how can it be claimed that there can be illness without disease? Is a disease process ontologically antecedent to illness? If there is disease without illness, is illness ever dependent on the patient’s insight into their experience? If a patient is 1) isolated on an island and clearly diseased, 2) has no community to claim illness on his behalf, and 3) the patient has no insight into his condition, then can we honestly claim that he is not ill?
As with papers already cited, it is a presupposition that the research in *Patients and Healers* deals with depressive syndromes.\(^{377}\) So, employing the disease/illness distinction it can be readily claimed that “Chinese popular sickness categories label depression as a somatic problem, while American popular categories label it as a psychological problem. Those labels shape the quality of the experience of depression in Chinese culture into a bodily or vegetative experience and in American culture into an intrapsychic and existential experience”.\(^{378}\) In other words, it is not merely the case that members of various groups construe symptoms in a different manner. Rather, the result of the cultural construction of illness as psychosocial experience leads to distinctive illness experiences such that “through labeling and the other cognitive processes, symptoms are socially constructed”.\(^{379}\)

This is Kleinman’s original theoretical model, and it is a very significant contribution to how we think about phenomena that appear to be instances of culturally specific patterns of illness, or what used to be called “culture-bound syndromes”. Sickness is imbued with cultural meaning and undertakes a particular form, illness. Sometimes cultural shaping is minimal and the illness appears very similar across cultures, but often the process results in illness that is significantly different in meaning and type of experience. “Sometimes the patterning of symptoms produces culture bound disorders, which [he] interprets to be illnesses associated with culturally unique patterns of meaning superimposed on *diseases that are universal*”.\(^{380}\) With this view in mind, we can understand why he takes issue with Singer above. At this stage in his thinking, he does not deny the universality of the disease, rather, he presupposes it. Furthermore, he sees culture as shaping it in a way that gives rise to a locally specific syndrome. That is to say, there are cultural variations in how the disease manifests as clinical illness, something that Singer appears not to appreciate. This takes a large step toward answering the third theoretical question above regarding how culture affects the morphology and course of an illness.

There are two possible mechanisms for cultural patterning of illness. The second of the two Kleinman does not emphasize and describes vaguely. It involves a “direct effect upon the physiological substrate”, bypassing cognitive appraisal and being outside conscious awareness;

\(^{377}\) Ibid., 19, 21. For instance, the book addresses “a model of how Chinese culture patterns depression” and “[t]wenty-five consecutive Taiwanese patients with the depressive syndrome”.

\(^{378}\) Ibid., 76.

\(^{379}\) Ibid., 77.

\(^{380}\) Ibid., 77. Emphasis mine.
how this might occur is not discussed in any detail, so I will ignore it for now.\textsuperscript{381} The first mechanism functions by means of subjective interpretation and cognitive appraisal of not only external stimuli, but also bodily emotional states. This is the mechanism he emphasizes, though the description is also vague. Some discussion of the effects of cognitive appraisal is worthwhile, as his specific examples have spawned significant controversy.

Cognitive appraisal is intimately related to the patient’s explanatory model (EM) of illness and includes what the patient believes with respect to etiology, natural course of illness, probable outcomes for the individual, and potential therapeutic options. Recognition of the importance of EM in health care systems has proven to be of unimaginable importance, as so often, the health care system breaks down when practitioner and patient have incommensurate EMs. The realization that attending to divergent EMs can lead to improvements in health outcomes is another of Kleinman’s great contributions. However, there is another aspect of EMs that is equally important. It may be the case that the patient attends to the EM of the practitioner, and unwittingly conforms to that EM, even to the point of experiencing symptoms that are expected from the perspective of the practitioner’s EM. In other words, “EMs may come to create the behavior they seek to explain”.\textsuperscript{382} If this scenario is possible, then the patient certainly can experience symptoms consonant with their own EM, so then the question becomes why the patient’s EM has the form that it does.

In Chapter 4 of \textit{Patients and Healers}, there are finally some concrete explanations as to why Chinese EMs contain the symptom complexes they do, and neurasthenia is the central topic. The case description is of a twenty-two-year-old Taiwanese male with stiffness/tenseness in his neck, insomnia, inability to concentrate at work, weakness, chronic ulcer, and anxious feelings, for whom various medications and herbs have had no effect. Western doctors, the patient, and his mother believe he has SJSR, but Kleinman concludes that it is a case of “somatization of dysphoric affect”. By expounding considerably on the cultural factors that he has raised in prior publications, we get a explicit position regarding the meaning and role of neurasthenia. First, he relies on a fundamental notion, namely, that “during their primary socialization, individuals in Chinese society learn that their own personal affects, especially strong and negative ones, should not be

\textsuperscript{381} \textit{Ibid.}, 80. I believe a direct effect on the cognitive substrate as a result of conscious or unconscious appraisal is probably a more likely scenario, which I return to at the conclusion of this project.

\textsuperscript{382} \textit{Ibid.}, 111.
openly expressed”. ³⁸³ Revealing affect, especially dysphoric affect, can place a variety of relationships in jeopardy, can disrupt social harmony, and can cause loss of “face”. I call this the “inscrutable Asian” claim. Second, “physical sickness, not emotional distress, is an excuse for failure in school, sports, work, personal transactions, and sexual relations”. ³⁸⁴ That is to say, there are socially sanctioned sick roles with respect to physical ailments and symptoms that are far more forgiving than if one were to exhibit shortcomings secondary to emotional instability. I call this the stigma/sick role claim. Third, the Chinese (and Hokkien) language is “rich in terms for bodily states and their dysfunctions, and for interpersonal transaction and their problems, but relatively impoverished in psychological terminology”. ³⁸⁵ I call this claim the “poverty of language” claim.

The last of these claims is a very serious idea that turns out to be an empirical question as to what is lexically available in the Chinese language. Presently, let it be clear that his position is that Chinese people learn not to talk about or attend to feelings and are subsequently deficient in identifying emotional states. For Chinese, “non-specific names lump together emotions that contemporary Westerners readily differentiate”, and emotion descriptors are comprised of Chinese characters that refer to bodily organs. ³⁸⁶ He considers this linguistic, descriptive deficiency to be recognizable in other cultures, including “traditional Western society”, ³⁸⁷ and his thinking on this matter appears to be heavily influenced by Julian Leff. ³⁸⁸ Leff’s paper in the first volume of the journal founded and edited by Kleinman would later be expanded into book-length form and would raise significant controversy over the problem of imposing Western ethnopsychologies during the research process. ³⁸⁹ Some of that arises briefly later in this chapter. Presently, a few words about Leff’s view in 1977 before I return to the three claims described above.

Briefly, Leff’s view of linguistic descriptions of emotion appears to be a variation of the Sapir-Whorf hypothesis. His primary claim is that “somatization of emotion . . . is actually built

³⁸³ Ibid., 133.
³⁸⁴ Ibid., 134.
³⁸⁵ Ibid., 135. In this case, he is referring specifically to Hokkien and Mandarin. I will return to this claim towards the end of this project.
³⁸⁶ Ibid., 135. Examples are 悲, 惡躁, 心情不好, 阜火. I fail to see how these terms are impoverished, not to mention that there are many more such expressions. Furthermore, etymological inquiry into English language terms indicative of emotional states will easily uncover physical/bodily origins for the words. For example, depressed, angry, nervous, anxious, among others.
³⁸⁷ Ibid., 135.
in to the respective languages” as a result of historical, evolutionary changes that occur in the semantic networks of any given cultural group. Starting with English and other Indo-European languages as an example, he suggests that the development of emotional vocabulary likely began with an undifferentiated term that “denoted the somatic experiences of unpleasant emotion”. The specific example offered is the root *angh*, from which anger, angst, and angina likely arise. His idea is that such a term originally “stood for the whole range of bodily experiences because they were undifferentiated, [but later] the word came to stand for the cognitive experience rather than the somatic experiences”. The word is thought to have split up over time and differentiated into various cognates that describe discrete feelings. This process is proposed as occurring in an uneven manner, faster in some cultures and slower in others, “so that some languages still lack an extensive range of words denoting the cognitive experiences of emotions, [and] languages with restricted vocabularies for the cognitive experience of emotion should be less capable of differentiating between the various unpleasant affects”. This theory appears identical to Kleinman’s discussion of Taiwanese affect.

Taken together, Kleinman’s three claims depict a situation wherein dysphoric affect is inhibited, inner psychological states are neglected, and physical complaints are substituted for psychological ones. His conclusion is that there is a drastic discrepancy in the phenomenology of depression between American and Chinese populations explainable by the cultural patterning of illness; “the illness is markedly different, but the disease would be the same in both populations”.

There is one final aspect of this model that deserves careful consideration. Kleinman is no ethnocentrist with disparaging views of the Chinese language’s ability to describe affect and of Chinese cultural sanctions against affective expression. The manner in which he elaborates his model is subtle, and one particular aspect must not be missed. For example, it is certain that Chinese people, like any other people, experience an array of affective states resulting from a variety of stimuli, which stimuli take on their meaning and significance owing to how they are evaluated in that culture. Prior to a process of cognition, primary “affective states are an essential psychobiological phenomenon, with physiological correlates, and as such are universal” human

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391 This proto-Indo-European root probably refers to a meaning of being "tight, painfully constricted, painful".
393 Ibid., 324.
In other words, there is no difference between the Chinese affective states and any other person’s affective states, prior to the process of cognizing about the state. Once categorized as sadness, anger, hot liver, fire qi, or some other such cultural label, the secondary affective state takes on its particular quality of experience; “differences in quality of secondary (cognized) affects result from their cognitive processing, not from their psychobiological substrate.”

This view, that universal, human experiences of affect are subsequently morphed via cognitive processing, is an interesting model of emotion that continues to deserve investigation. It appears to preclude the possibility that there are culturally specific affective states at the level of the psychobiological substrate, a question that still needs to be addressed by experimental psychology and cultural neuroscience. Nevertheless, he goes the extra step and simultaneously proposes the idea that troubling affect is managed within Chinese society through dissociation, minimization/denial and somatization. For the reader familiar with psychoanalytic models of mind, such influences are clearly seen in Kleinman’s view of affect management as forms of defense mechanisms, which view even goes as far as labeling bodily symptoms “forms of somatic masquerade”. This line of thinking is continued across other publications, showing up just one year later with the claim that dysphoric affects are “articulated” in culturally approved idioms in the form of somatic rather than psychological distress.

In summary, we have the following position: particular aspects of Chinese culture acquired through socialization define and constrain what kinds of psycho-social stimuli give rise to particular types of affective states. Affective states themselves are universal forms of human experience that are psychobiological in nature prior to cognitive processing. Cultural norms

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395 Ibid., 147.
396 Ibid., 148.
397 Minimization is relevant to SJSR insofar as patients are claimed to minimize or outright deny the presence of disturbing emotions; Kleinman admits that many patients deny feeling depressed or sad. Dissociation is less relevant, and refers to the idea that patients separate themselves from troubling emotional stances by entering trance-like states (at a shamanistic temple, for example) or by displacing emotional states onto others (anger at children). Somatization is the primary coping strategy offered, which is indirectly related to the minimization of emotional contents simultaneously. Interestingly, in Chapter 4 Kleinman offers three descriptive case histories as support for his interpretation regarding minimization, dissociation, and somatization. He re-uses, verbatim, the cases of Ms. Liu (accountant) and Mr. Hung (Navy Captain) mentioned in 1977. In this current instance, we encounter yet another Mr. Wang, who is clearly a new case.
398 Ibid., 149.

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acquired through socialization dictate that affect is largely to be suppressed (inscrutable Asian), which norms interact to produce a linguistic system that neglects the development of psychologically sophisticated language (poverty of language). As dysphoric affects arise, linguistic descriptions “minimize” or “deny” emotional content and significance, which gives prominent place to bodily/physical experiences that are then the source of primary symptom presentation (somatization). Psychiatric labels are stigmatizing. Hence, SJSR is a culturally specific form of somatic presentation of depressive syndromes in bodily language. The interpretation of SJSR as presented in Patients and Healers constitutes a model in NCCP that appears to have exerted considerable influence since its systematic presentation in 1980, and that influence can be seen in a number of other publications from that decade.

4.3 Writings on Somatization Following Patients and Healers: 1982–1984

Kleinman continued with several other publications into the 1980s. Normal and Abnormal Behavior in Chinese Culture has already been mentioned; it only has a small number of pages dedicated to SJSR and repeats the main claims already covered.\(^\text{400}\) However, the co-editor of that volume, Tsung-yi Lin wrote a piece in 1982 that is worth mentioning because of an irony that the reader may appreciate if it is pointed out directly. Lin describes his motivations for writing “Culture and Psychiatry: a Chinese Perspective” as arising largely from the need to respond to the, then current, situation wherein no clear relationship could be defined between the state of “orthodox psychiatry” and the growing field of cultural psychiatry. He addressed the question of whether cultural/comparative psychiatry has a pragmatic usefulness for clinical practice. Specifically, he outlined two tendencies in psychiatry that he thought were problematical and could be prepared for remedy by the growing and new cultural approach; these he referred to as “ethnocentrism” and “a belief in clinical universalism”.\(^\text{401}\)

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\(^{400}\) See Normal and Abnormal Behavior, 333–8. With respect to Chinese culture he states, “introspective orientation, particularly in relation to negative affective states, is discouraged . . . The Chinese thus do not have an elaborate psychological vocabulary to characterize the quality of distress, and negative emotion appears to be muted or suppressed. Instead, distress seems to be expressed somatically with less obvious evidence of depressive affect or anxiety”. The reader will readily recognize (in the order specific to this citation) the poverty of language claim, the inscrutable Asian claim, and the somatization claim.

Regarding ethnocentrism, Lin made reference to any hypothetical “psychiatrist who tends to judge patients, or human beings in general, as normal, or abnormal or even pathological, based on the criteria of his own culture”. The reader will recall that this is precisely the position Kleinman referred to when defining his “category fallacy”. Clinical universalism, on the other hand, “originates in the belief that all human beings basically live, feel, think and behave alike, so that the symptomatology, course, and outcome of a disease, as well as its methods of treatment or theories of its causation should apply in all cases in spite of any individual, racial, ethnic or cultural differences”. As concrete areas of focus with respect to these issues, Lin discusses major psychoses, minor mental disorders, and patterns of help-seeking among Chinese.

Lin summarized his article with the claim that “the phenomenology of depression differs vastly from that in the West and is characterized by somatization”. He gave four socio-cultural factors that he believed accounted for the feature of somatization, citing Kleinman among others as supporting sources. These are: 1) as traditional Chinese medical theories and folk beliefs influence the perception of mental disorders, it is to be expected that patients describe their symptoms in the language of “dysfunction or imbalance of bodily organ systems”, which is consonant with classical notions of a “unitary psychosomatic system”; 2) somatic complaints are recognized as belonging to a socially sanctioned sick role; 3) there is a cultural taboo regarding discussion of emotions directly in public, leading to psychical and emotional states being prevented from surfacing both to the self and others’ attention; and 4) somatization may be a Chinese cultural trait, “consisting of the predominance of the oral-hypochondriacal quality.”

The reader will notice that Lin, being a Chinese who grew-up in Taiwan, was unwilling to offer as an explanatory factor that the Chinese language is deficient in its ability adequately to describe emotional experience. However, clinical universalism and ethnocentrism are present, in part, insofar as depression is viewed as a universal phenomenon with a presumed etiology and presumed influence on the human person. Furthermore, a patient’s experience is interpreted in the context of this Western, psychiatric category, despite whatever resistance to the category may be offered by the patient. Lin’s conclusions about somatization are the same as Kleinman’s, and the experience of the Chinese patient is interpreted through the framework of the clinical category of depression.

402 Ibid.
403 Ibid.
404 Ibid., 241.
405 Ibid.
albeit with somewhat less derogatory implications. For our present purposes, I will briefly turn to Kleinman’s conclusion regarding minor mental disorders, of which SJSR is considered to be the majority example, before moving on to other researchers. I believe the reader should be able to recognize that both ethnocentrism and clinical universalism, as he defined them, are precisely what we have encountered when it comes to their model of SJSR thus far.

In January and February of 1982, Kleinman co-authored a two-part review of “depression and Somatization” with the Wayne Katon and Gary Rosen. Having presented a view in *Patients and Healers* that attempted to justify the diagnosis of depression among Chinese patients when dysphoric affect was denied and/or physical symptoms predominated, there remained the issue of such patient presentations here in the USA. As I point out in a moment, the prevalence of “somatization” in the USA poses a serious problem for the cultural model Kleinman proposed, which necessitated further commentary in 1984. However, a general model of somatization that was not necessarily specific to Chinese patients needed to come first. Part one of their review admits that “as many as 50 percent of patients utilizing primary care clinics actually have psychosocial precipitants as opposed to biomedical ones as the main cause of their clinic visits”. This slippery language, however, avoids stating that fifty percent of patients presenting to primary care clinics “somatize”. That would undermine the unique Chinese somatization argument. However, the claim is made that more than half the patients going to primary care clinics have somatic presentations as part of the “depression”. They attribute such numbers to the inability of primary care physicians to conceptualize their patients as having depression without the patient perceiving and/or reporting the requisite mood and/or affective state. “Thus a patient who has not developed the language to label and report his emotional states, or who utilizes defenses or coping styles that minimize affects or who believes his problem is a physical one will not be

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408 With this use of language, the game is rigged in favor of the theory. It is one thing to claim that patients present for care due to a number of somatic complaints that have no obvious physiological cause. It is another thing to presuppose that patients are depressed and are presenting with somatic symptoms of depression. This is a very old logical fallacy known as “begging the question”. That is, taking for granted the thing that is to be demonstrated. 409 I will remind the reader that the clinical diagnosis requires a mood component, hence all the effort at claiming the mood component is really there, if only in a masked manner.
recognized as depressed by many physicians”. 410 This position is familiar, and relies predominantly on the poverty of language argument once again; this time however, a developmental model is provided such that the language system itself (English, for example) need not be deficient in its ability to describe psychological states, but instead the individual persons are deficient as a result of their upbringing in families that fail to talk about and label disturbing affects. In other words, they “postulate that it is in families that have not developed psychological language for articulating unpleasant emotions that would be most apt to see the selective focus on the somatic manifestations of depression”. 411 That is to say that children learn through familial reinforcement how to elicit care from family by, for example, “complaining about a headache rather than about being sad or depressed”. 412 These ideas are supported by findings that such patients often have mothers with the same “somatizations” and respond to Tricyclic antidepressants, which is questionable support at best. 413 At the center of this whole position, however is their theoretical view of affect.

What ought we to make of the claim that the “affective component of depression can only be known to the patient through cognition”? Is it true that “without the cognitive perception of the feeling component, the depressive disorder exists as a somatic syndrome expressed by vegetative symptoms”? 414 This is a question for affective and cognitive neuroscience and psychology; suffice it to say that, at best, this seems a very doubtful claim. It seems unlikely that affect is unrecognized or inaccessible, except as somatic sensation, to those who are unable or fail to cognize it (e.g., other primates, persons with intellectual disability, etc.). However, antecedent even to this theoretical issue, is their presupposition that the underlying phenomenon in question is “depression”. Regardless, there is no shortage of serious theoretical and philosophical questions that are left un-attended in this attempt to frame the variety of physical complaints that present to primary care providers as “somatized depression”. Two years later, Katon and Kleinman’s discussion of somatization was somewhat more even-handed, as it was discussed in the context of

410 Ibid.
411 Ibid., 132.
412 Ibid.
413 Ibid., 133. I will avoid discussions of the pharmacology of Tricyclic antidepressants. Suffice it to say that it is now known that these drugs work for a wide variety of syndromes and are also effective against pain. For the interested reader, see Chapter 15 of Laurence Brunton, Bruce A. Chabner, and Bjorn Knollman, Goodman and Gilman’s: The Pharmacological Basis of Therapeutics, 12th ed. (McGraw Hill Professional, 2011).
the recognition that somatic complaints are a common feature of patients with depression, panic disorder, somatization disorder, histrionic personality disorder, borderline personality disorder, grief syndrome, posttraumatic stress disorder, factitious disorder, hypochondriasis, and malingering.\textsuperscript{415} Nevertheless, recognizing that a large number of patients are eventually diagnosed with depression after many months of somatic presentation does not itself validate the claim that the somatization is a “masked depression”;\textsuperscript{416} rather it raises the question as to whether the eventual diagnosis is an example of post hoc ergo propter hoc.

4.4 Social Origins of Distress and Disease: SJSR in Hunan, China

Returning specifically to questions regarding Chinese culture, Kleinman followed up with a large report in 1982 that served as the primary source material for his second most influential monograph, published in 1986 and which I refer to as Social Origins.\textsuperscript{417,418} As such, I address only the monograph here. This later work, which he described as a work on affect and affective disorder, includes additional material that is not found in the earlier paper. These consist of a historical background chapter on neurasthenia in the West and China, a chapter on depression,\textsuperscript{419} and one on somatization itself. Findings from the clinical research undertaken in 1980 begin in Chapter 4, and Chapter 5 includes follow-up that occurred in 1983. Chapter 6 presents clinical cases, and Chapter 7 is a theoretical discussion of SJSR. An epilogue concludes the book. In the next few paragraphs, I try to summarize some of the key aspects of Social Origins for the reader in a manner that problematizes Kleinman’s views.

The clinical research presented in Chapter 4 of the text took place in 1980 at an outpatient psychiatric clinic in Hunan, China, and the study sample included 100 patients with a diagnosis of SJSR between the ages of eighteen and fifty-six. Each patient received a psychiatric assessment (a questionnaire) to assess for DSM-III diagnoses as part of a psychiatric interview, in addition to


\textsuperscript{416} Ibid., 212.


\textsuperscript{418} Kleinman, Social Origins of Distress and Disease: Depression, Neurasthenia, and Pain in Modern China.

\textsuperscript{419} The discussion of both depression and somatization in these two chapters is nearly identical to, and cites the same references as other works discussed thus far. There is essentially nothing new in those two chapters. The historical chapters are referenced in Chapters 2 and 3 above.
ethnographic interviews that could last up to two hours.\textsuperscript{420} Patient symptoms, living situation and life events, meaning of and duration of symptoms, patient views of etiology, and previous experiences and medical help seeking were all assessed. After interviews, patients were counseled regarding current medications and/or offered medication if it was thought to be indicated. Patients were asked to return several weeks later, 76 of whom were able to do so. Overall, 87 of the 100 patients were found to meet criteria for major depressive disorder, with more than half meeting definition for chronicity lasting more than two years. On average, most patients complained of around five physical symptoms such as headache, insomnia, dizziness, pains (back pain, chest pain, and other pains), weakness, loss of energy, and poor concentration.\textsuperscript{421} Of the 100 patients, 39 initially expressed no affective or mood complaints, but among those who were re-labeled as depressed, dysphoria or anhedonia was elicited over the course of the interview in one hundred percent of the patients (hence labeled as depressed). That is to say, 87 of the 100 patients admitted they had experienced either a) non-specific displeasure, unhappiness, or b) loss of interest in all or most of their usually pleasurable activities; which are criteria for depression according to DSM-III, as can be seen in Figure 17 below.

A great deal of space in \textit{Social Origins} is used to describe the meaning of patients’ illness experiences. For instance, it is stated that in ninety-three percent of cases, the illness significance “was to express personal or interpersonal distress or unhappiness”.\textsuperscript{422} Other examples are gaining time off work or receiving care from family or friends. I will not take time to discuss these issues as they are completely irrelevant to the fundamental question that I am pursuing. The reason they are irrelevant is because these significances, whatever they are, would still be the same whether Kleinman chose to exchange one diagnostic label for another or not. Why insist that the patient is “somatizing”? In other words, his reduction of neurasthenia into somatized depression is independent of the significances attributed to the experience. The experiences and their cultural functions would remain whatever they are, despite the label.\textsuperscript{423} This is so even in the event that

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\begin{itemize}
  \item \textsuperscript{420} It is not necessary to address all of the methodology of the study, which is available on pages 68–75 of \textit{Social Origins}. Instead, I focus on conceptual issues that constrain the findings of the study.
  \item \textsuperscript{421} This list is not exhaustive of the somatic complaints but serves to demonstrate the complaints that appeared in the majority.
  \item \textsuperscript{422} Kleinman, \textit{Social Origins}, 91.
  \item \textsuperscript{423} See my “thought experiment” at the end of the discussion of \textit{Social Origins} below.
\end{itemize}
Kleinman is wrong and SJSR is a valid ontological category that describes a specific pathological condition. This same tension can be seen in his discussion of follow-up in 1983.

Figure 17: DSM-III (1980) Diagnostic Criteria for Major Depressive Episode

Returning to China in 1983, Kleinman conducted a study “to determine to what degree somatic complaints among these patients were amplified or dampened in response to work, family, and other social problems over a period of years, and to what extent both chronic pain and depression had responded to medical treatments”. He hypothesized that the “social context of illness would be the major determinant of persistent somatization”. Following up on 21 cases, he found that 8 of them continued to meet the DSM criteria for major depression. Another 5 met criteria for dysthymic disorder (basically a chronic depressive disorder). He further found that those who improved had undergone some significant life change that contributed to their improvement, such as changing jobs or being reunited with a loved one. Nevertheless, it appeared

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425 Ibid., 96.
426 Ibid.
that 20 of the 21 follow-up cases still had significant physical complaints which included the following: Headaches (20), weakness/tiredness (20), insomnia (18), dizziness (15), bad memory (13), other pains (8), and poor appetite (7). Most interesting, however, was that just over half of these patients had embraced the idea that their complaints were psychological in etiology, which was a change from his 1980 findings. Kleinman attributed this switch in explanatory model to the fact that he and his colleagues attempted to convey a psychosomatic stress model during their initial interactions with patients three years prior. One seeming consequence of this switch was a decrease (70%) in medical help seeking, whereas only one-third of those who continued to maintain a non-psychological model of their experience were found to have reduced medical visits.

One of the very fascinating conclusions Kleinman draws from his follow-up study pertains to what he sees as a shifting view regarding psychotherapy. When eight patients requested treatment with psychotherapy, he “wondered whether psychiatry is contributing to the advance of modernism in the clinic, a form of Westernization of Chinese culture by ‘rationalizing’ (explaining and legitimating) psychological idioms and self-images and thereby transforming neurasthenia into a disorder of ‘affect’”. This sea change in the cultural mode of communicating distress, as he put it, is something that he thinks was well on its way, and had already taken hold among the more educated class of teachers and professionals. At least in this regard, he may very well have been correct in stating that such a change had been occurring or would occur, especially as Chinese continued to adopt imported ways of thinking and talking about their experience. The obvious and more important question is whether or not the epistemic framework that he had positioned onto those patients’ experiences mapped on to what was “really” going on for them.

Kleinman’s arguments are tantamount to the following claims: these patients report symptoms consistent with the cultural category for SJSR. Those symptoms and the patients’ explanatory models for illness are richly imbued with somatic language, bodily experience, and physical (rather than psychological) explanations as to etiology. Those symptoms and models perform the cultural work of x, y, and z. Therefore, their illness is a somatization of major

\[427\] Ibid., 221. It should be apparent from these numbers that many of the patients still had multiple complaints.

\[428\] He considers this switch a helpful contribution to “reducing the overutilization of medical services” (99).

\[429\] Ibid., 99. Parenthetical comment is his.

\[430\] Ibid.
depressive disorder. The conclusion obviously does not follow without some intervening premises, which we have already seen in Patients and Healers. These are reformulated as follows: 1) psychiatric problems are so stigmatizing that the needed cultural work could not be accomplished with a psychiatric label, 2) patients minimalize or deny the affective component of their sickness, and 3) patients are not able to describe their real problems because they lack the linguistic capacity. As we have seen in Social Origins, the patients presented to a psychiatric clinic, nullifying (1). Most patients appeared able to describe affective issues, nullifying (2) and (3). What this leads me to conclude is that, for at least some of these patients, Kleinman probably imposed the diagnosis of depression as a result of looking for it.431 That some patients embraced a psychological model after the fact demonstrates that people are able to take on new experiences when it is suggested to them. It does not validate his reduction of SJSR to depression any more than response to antidepressants demonstrates “a depression”.

In the final substantive chapter to Social Origins, there is a section titled “What is Neurasthenia?”432 In that section, many pages are spent repeating and describing the varieties of ways that neurasthenia serves as a “culturally approved and socially legitimated illness behavior”.433 His concluded that “neurasthenia can be most fruitfully conceptualized as illness experience—a culturally salient form of chronic somatization that acts as a final common behavioral pathway for several distinctive types of pathology, of which major depressive disorder is the principal disease”.434 Despite this conclusion, he suggested that SJSR could reasonably be retained in Chinese diagnostic manuals, presumably because of its salience and the cultural work it performs.435 He nevertheless viewed it as depression, and expected it to become increasingly viewed as such over time.

Of course, the obvious “thought experiment” is to consider a patient who believes they have SJSR, meets all traditional symptom criteria, but does not “employ” that model for any social

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431 In fact, he explicitly states that he “reinterpreted the patient’s neurasthenia as major depressive disorder” (161).
432 Ibid., 152.
433 Ibid., 161.
434 Ibid., 165. Emphasis is his in the original, which makes continued use of his framework distinguishing illness from disease.
435 On page 152, he even allows that SJSR is both illness and disease. However, he makes clear that this means disease merely nominally as a consequence of continuing to be listed in Chinese diagnostic manuals. There is no doubt that he believes the patients’ underlying disease is Major Depression.
gain. That is, he does not attempt to get out of work, account for a failed exam, or otherwise achieve anything with a socially legitimated illness behavior. What if such a person suffered silently, fulfilling all their familial, social, and interpersonal obligations? Surely such persons exist, and considering such a person questions the relevance of the myriad pages spent justifying the claim that SJSR should be recognized as somatized depression because “somatization” performs cultural work.

While the discussion of this pivotal text in the literature of 1980s NCCP could proceed much further, a few words here should conclude this section. The works discussed thus far created a renewed interest in the conceptual category of somatization, long held to be a mechanism of ego defense by psychoanalysts. NCCP reframed it as a “culturally constituted coping strategy (or defenses)” and as a mechanism for coping with dysphoric affect in Chinese culture. Cultural psychiatrists again reviewed the literature on somatization phenomena, attempting to frame what types of somatization could be recognized. Laurence Kirmayer’s categorization includes three types: 1) presentation or amplification of physical symptoms merely “in the absence of” organic pathology, 2) presentation of physical symptoms “in place of” personal or social problems, or 3) manifestation of physical symptoms “as defense” against unpleasant emotion. From this vantage point, the NCCP classes SJSR as type (2), with the view that SJSR labels a somatization process whereby cultural learning facilitates the presentation of physical symptoms in place of personal or social problems.

Kirmayer further organizes models of somatization into seven explanations for occurrence: “(a) the somatic concomitants of emotion and affective disorder; (b) a consequence of an incapacity for, or suppression of, emotional expression; (c) a result of attention focused on the body; (d) the use of the body as a channel of communication; (e) an idiom of distress or way of making meaning out of suffering; (f) a path to enter the sick role; (g) a result of the organization of health care delivery”. With this manner of conceptualization, NCCP can be seen to employ all of the models to some extent. As I have made clear, model (b) is among the most controversial, prompting Kirmayer to point out that “judging the differentiation of experiential categories within

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436 Patients and Healers, 151, 158, and 172. Page 172 refers to “cognitive coping strategy”, which Kleinman stopped using.
a culture by its lexicon is a highly questionable practice”. As such, claims regarding a broad, culture-wide form of somatization (as some have done) most certainly should not rely on notions like alexithymia either, which is as problematic as Leff’s evolutionary view.

In addition to garnering attention from culturally oriented psychiatrists in the West, Social Origins and its preliminary report in 1982 caught the attention of Chinese psychiatrists who disagreed with the idea that SJSR as a diagnostic category had been undone. Beijing University Institute of Mental Health professor Zhong Youbin argued that despite having conceptually arisen with Beard’s Neurasthenia, SJSR in the Chinese context was conceptualized rather differently than the “wastebasket” diagnostic category that it had been when first formulated. That original category admittedly included those patients with physical ailments arising from panic disorder, anxiety disorders, depression, and “hysterical conversion” (歇斯底里转化症状), but after defining those conditions carefully and separating them phenomenologically, physicians are still left with a group of patients that do not quite fit into these categories. After a considerable background discussion of neurosis including the subjects of “masked depression” (隐形性抑郁), “hidden depression” (隐蔽性抑郁), and “missed depression” (漏诊的抑郁), Zhong concluded that the category of depression had become broad enough to capture patients with all kinds of complaints, which is exactly the criticism of SJSR as a category. He conceded that an argument could be made for a “masked depression” if all SJSR patients remitted after anti-depressant therapy, but experience showed that this was not what happened in practice. Instead, there were patients who presented with fatigue, headache, and other symptoms, admittedly psychological in origin, for whom anxiety and depression did not seem to factor and antidepressants did not seem to help. For Zhong, forcing those patients into a DSM category seemed early and without foundation.

Rather than continue further with this line of discussion, it is more profitable to return to those subsequent research projects that have been influenced by, or continue, Kleinman’s views of SJSR.

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439 Ibid., 250–51. He goes on to say that “A more sophisticated contextual approach that examines the pragmatics of language through ethnographic research suggests this apparent lack of differentiation may be overstated or illusory”.


4.5 Culture and Depression: Thoughts on Somatization from 1984 and 1985

As this volume is over five hundred pages in length, there is not presently space to examine the contribution of every author. Instead, I want to draw the reader’s attention to the material of just four. First, a little can be said about Kleinman’s section, “Somatization: The interconnections in Chinese society among culture, depressive experiences, and the meanings of pain”, co-authored with Joan Kleinman. Afterwards, I mention Obeyesekere’s “Depression, Buddhism, and the work of culture in Sri Lanka”. Lastly, a few words from Catherine Lutz and William Beeman regarding translation and linguistics from the perspective of linguistic and cultural anthropology can be applied to what has been covered so far throughout this chapter.442

The title of the Kleinmans’ chapter in Culture and Depression gives the impression that they are prepared to discuss “depressive experiences” rather than major depressive disorder (the diagnosis), which is what many other contributors to the book have done. However, the orientation to the chronic pain complaints is based on the same group of patients from 1980 that A. Kleinman diagnosed as having major depressive disorder. Once again, I will not address the case descriptions because I do not think they are helpful. Not only are they verbatim the same group of cases that appear in Social Origins, but there is no way for any reader to know what was done well or what may have been missed in the process of formulating those descriptions.443 Instead, it is better to look at what is done differently in this chapter and compare it to some of what is repeated.

One interesting aspect of this chapter in Culture and Depression is that there is a reinterpretation of the 1980 findings (from Social Origins as described above) in two regards. First, they claimed that, “we suggested that neurasthenia and depression could be understood as

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442 “Depression and the translation of emotional worlds” (Lutz) and “Dimensions of dysphoria: The view from linguistic anthropology” (Beeman), are chapters 2 and 5 of Culture and Depression, respectively.
443 Additionally, I am not sure that qualitative data, filtered through one person, is the best form of data when it comes to a topic as controversial as SJSR. What’s more, the reader who systematically goes through the works of Kleinman will find the repetition of a small number of cases. As I have already demonstrated, some of the cases change. Another example can be found in the Illness Narratives (1988), where the case of Yen Guangzhen is repeated. A footnote states, “When I originally wrote up this case, I emphasized the complaint of headache and deemphasized the other complaints in order to stress the chronic pain syndrome. The current description is fuller and brought up to date”. He is referring to the original formulation in Social origins, (p. 134–137) which was written-up some three years prior. Given the seriousness of the claims and the controversy of SJSR found in the earlier work, it seems like the “fuller and... up to date” formulations would have been given in the original, not in a later book that does not offer anything controversial or new.
distinctive cultural construals of the same psychobiological state in which Chinese and American cultural values influenced both lay and professional constructions of distress”. It seems impossible to find that interpretation anywhere prior to its appearing in *Culture and Depression*, which has contributions from so many anthropologists critical of Western psychiatry. In fact, such a view did not appear in English at all in the 1980s. But A. Kleinman does frame the issue in this manner when writing for a Chinese audience, as I show below. Second, there is more openness to alternative views of patient experiences than was expressed in *Social Origins*, despite repeating the claim that “Depressive disorder . . . seems to have conduced to the development of chronic somatization in most of our cases”. While still tending toward this view (contrary to the claimed interpretation above), some nuance was added to the original position.

Specifically, the 1980 study and its follow-up are reframed. Recall that the chief complaints (*Social Origins*) of all the neurasthenic patients (n=90) were somatic in nature, as we have already seen. Also recall that dysphoria could be elicited from all those same patients. Among those 90, 80 were re-diagnosed with Major Depression, and 71 were treated with tricyclic antidepressants. Approximately five weeks later, 58 of the 71 showed improvement. Of those, 46 showed substantial improvement. Though 1 patient had no problems, 30 reported minor symptoms, 15 had substantially fewer symptoms than originally, and 12 still had significant problems. No improvement was shown by 6 of the patients, and 7 were worse. This is best viewed diagrammatically, as in Table 2.

| Table 2: Self-assessed improvement among 71 patients treated with tricyclics |
|---------------------------------|--------|
| Completely, with no current problem | 1      |
| Only minor, current problems      | 30     |
| Still some problems, better than before | 15     |
| Still significant, current problem | 12     |
| No improvement                    | 6      |
| Worse than before                | 7      |

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444 Kleinman, Kleinman, and Good, “Somatization,” 438. He goes on to say that “our anthropological readers generally took this to be our interpretation, but our psychiatric readers in the United States or China did not”. I have already demonstrated numerous times that he clearly claimed SJSR to be somatized depression, with depression serving as the actual disease. See his changed position in the Chinese language paper discussed below.

445 Ibid., 471.
There are a number of ways to think about this table, but the most obvious is to conclude that after a month of medication all but one patient continued to have physical complaints of some kind or got worse. Remember that follow-up took place again three years later, with only 21 patients available for interview. Of those 21 patients, 7 claimed that their pain was the same as before, 10 claimed 50% improvement, and 3 claimed 75% improvement. Nevertheless, there continued to be significant somatic complaints, as can be seen in Table 3.

Table 3: Chief complaints at follow-up in 1983, out of 21 patients available

<table>
<thead>
<tr>
<th>Complaint</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weakness/tiredness</td>
<td>20/21</td>
</tr>
<tr>
<td>Headache</td>
<td>19/21</td>
</tr>
<tr>
<td>Insomnia</td>
<td>18/21</td>
</tr>
<tr>
<td>Dizziness</td>
<td>15/21</td>
</tr>
<tr>
<td>Bad memory</td>
<td>13/21</td>
</tr>
<tr>
<td>Poor appetite</td>
<td>7/21</td>
</tr>
</tbody>
</table>

These patients present a problem. Not only did the initial group largely reject the label of “depression”, but their physical complaints continued after treatment. Subsequently, a three-year follow-up with a subset of those patients indicated significant, chronic symptoms. This situation deserves more explanation, which comes toward the end of the Kleinmans’ chapter. 446

Somatization is defined in this chapter as “the expression of personal and social distress in an idiom of bodily complaints and medical help seeking”. 447 Relying on research papers published two years after his Hunan study was completed (citing Rosen, 1982), Kleinman re-conceptualized somatization as being categorized into acute, subacute, or chronic forms. 448

1) Acute somatization is the result of an acute stress reaction to some life event that effects the autonomic nervous system in a manner that gives rise to psychophysiological symptoms. These symptoms last days or weeks.

2) Subacute somatization is framed as a situation where the patient, “abetted by the family and health professionals, systematically focuses on and thereby amplifies the physiological symptoms, while at the same time he minimizes and thereby dampens their affective and cognitive

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446 Presumably after the manuscript of Social Origins was largely completed. It seems clear that Social Origins was already complete as it is the longer and more complete work. Sections of it appear to have been copied and pieced together to make the chapter for Culture and Depression.


448 Kleinman, “Neurasthenia and Depression,” 171. This view of somatization is absent from Patients and Healers.
concomitants”. The initiating cause of the problem would be either from a prolonged response to stress or from the development of a psychiatric disorder, “most usually depression and/or anxiety disorders”, and symptoms would last several months. 3) The chronic cases of somatization, then, are seen as much longer periods of physical complaints that are accompaniments to persistent psychiatric disorder; again, bodily symptoms are emphasized and the affective components are deemphasized, minimized, or denied. However, an additional form of chronic somatization is also offered. Specifically, he suggests that acute or subacute somatization may be prolonged and transformed into a long-term sick role. In other words, even “in the absence of medical disease or psychiatric disorder”, chronic somatization can become adopted as a “habitual coping style or idiom of distress that is learned via childhood socialization in family, in school, and in other sectors of the local systems under the aegis of society-wide, paradigmatic cultural norms”. This more complete interpretation resolves/removes the need to diagnose a psychiatric disorder in the SJSR patients viewed as exhibiting somatization, although A. Kleinman had done so previously. Furthermore, it offers an account for the claim that Chinese tend to somatize, even if there is no disease. That is to say, Chinese learned a “somatic style of coping with stress and of articulating distress” from their families and culture.

This more nuanced approach to SJSR seems somewhat more palatable than what I have described to the reader so far, even though it still has problems. They avoided any strong version of the “poverty of language” argument as I previously outlined it. Presently, it seems that it might have sufficed to say that the poverty of language was learned in families, which is something we saw above as well, but that would not have explained how an entire cultural milieu tended towards a minimization of affect and an emphasis on bodily symptoms. Regardless, the troubling claims that founded A. Kleinman’s model have already been stated in Social Origins and Patients and Healers though they have been slightly modified in this small chapter. There appear to have been significant pressures in Culture and Depression that led to modifying this position to the form found here. I briefly address some of those pressures below.

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449 Ibid.
450 Ibid., 472.
452 Ibid., 473. It should be mentioned that 36% of his original 100 SJSR patients had a family history of SJSR.
Only the most obtuse reader would fail to recognize that a number of the anthropologists writing in *Culture and Depression* have used the opportunity to call for a more sophisticated conceptualization of depression than occurred in A. Kleinman’s previous work. This probably had the positive effect of helping him, as editor, to reframe his stance slightly in his own contribution, which serves as the final chapter of the book. Obeyesekere was the most straightforward in his criticism. Lutz and Beeman dealt with slightly more complicated issues.

Gananath Obeyesekere took issue with the most obvious conceptual problem facing cross-cultural work by strongly warning that “one must not delude oneself with the false notion that the existence of patients labeled depressives proves in any way the existence of a disease known as ‘major depression’”. The conceptual problem here is very similar to Kleinman’s category fallacy, insofar as the label “depressives” can easily constitute the application of a category outside of an appropriate context and thereby reify the category. Obviously, the use of such labeling has to do with a deeper epistemic claim about human experience. In other words, the act of applying the label constitutes a claim to understand what is “really the case”. Obeyesekere’s main counterexample to the act of such diagnostic labeling is his own experience with Buddhism in his home country, Sri Lanka. From this perspective, what “is called depression in the West is a painful series of affects pertaining to sorrow and is caused by a variety of antecedent conditions—genetic, sociocultural, and psychological”, but they exist in the West in a “free-floating manner” without a philosophical cohesion to give them meaning and are therefore subject to being labeled as illness or disease. Alternatively, he viewed the philosophical comportment toward life as articulated in Sri Lankan Buddhism as being grounded in a system of meaning where affects of sorrow, suffering, and hopelessness define a human condition that should not be labeled either illness or disease. Exploring this further is beyond the scope of this chapter. Suffice it to say that Obeyesekere’s view of culture, and its role in framing human existence and


454 I remind the reader that “diagnosis” originates in the Greek etymology of “dia” and “gnosis”, to know-through or thoroughly. From *gnosis*, of course we get knowledge, gnostic, etc. That said, the act of making a diagnosis constitutes an epistemic claim, often about the ontology of some phenomenon in question.


456 These three marks of existence are *anicca*, *dukkha*, and *anatta* (impermanence, suffering, and non-self). Recall that the East Asian tradition translates the 三相 as 無常, 苦, and 無我.
affectivity for the individual person, serves as a warning for the psychiatrist who is apt to label as depression those expressions of dysphoria that might otherwise be intimately grounded in a normative mode of experience. Given these considerations, I think it was wise for A. Kleinman to alter his position so that patients need not be labeled depressed merely because they meet criteria of the DSM, and it was probably with such a consideration in mind that he re-framed chronic somatization as possibly occurring in the absence of psychiatric or medical disease.457

Catherine Lutz offered a criticism of Western psychiatry that was informed by her anthropological work with the Ifaluk of Micronesia.458 Beginning with the idea that depression as a conceptual category is fundamentally emotional in nature, any discussion of depression must begin with the antecedent analysis of emotion. Specifically, she took issue with the idea that emotions are “natural, precultural facts”.459 She argued that this type of notion is a consequence of what she sees as Western ethnopsychology’s dichotomization between emotion as feeling and cognition as thought. In other words, Western intellectual history gives rise to the idea that emotion is primarily an “internal, psychobiological species of feeling”, that stands in contradistinction to cognition. As she quoted directly from Patients and Healers, there should be little doubt that her criticism applies directly to the type of position taken by A. Kleinman when he claimed in 1980 that his Taiwanese patients had a universal, primary (un-cognized) psychobiological state of affect, that was later cognized into its secondary, culturally shaped form. She used her own ethnographic work to suggest ways that emotions exist as culturally constructed judgments, which I will not address here.461 Adequate for our discussion, however, is the challenge to the assumption that affect is antecedent to and ontologically separate from thought. She also spent several pages

457 See previous four paragraphs. Nevertheless, he still labels it as “somatization”, which implies a mind-body dualism that is probably exaggerated, but not necessarily untenable.
459 Ibid., 61.
460 Ibid., 65. Her criticism appears to refer to sentences like this one, which were addressed in the discussion of Patients and Healers above: “[A]ffective states are an essential psychobiological phenomenon, with physiological correlates, and as such are universal”. Recall that he went on to claim that the affective state exists first in an uncognized form, later to be shaped by culturally informed cognitive categories.
461 Her own fieldwork, I must admit, is not that relevant for me. Sufficient for our case is when she points out the disagreement between psychological/psychodynamic models of depression in contrast with cognitive theories like those of Aaron Beck.
addressing Kleinman’s apparent reliance on the thinking of Julian Leff, but since that makes up a large part of Beeman’s criticism, I will turn to Beeman for that context.

Writing about dysphoria from “the view of linguistic anthropology”, William Beeman was not shy about stating that the “assumption of universality of depression seems ill-founded”. Nevertheless, he addressed the role of language in both the expression of dysphoria as well as some varieties of therapeutic interaction aimed at treating it. As not to belabor the point, I focus on his criticism of Leff. He began by saying the following: “I must confess that I feel somewhat foolish addressing Leff’s schema, since it is ground that has already been worn bare by the tread of many others who have come before me. Nevertheless, this schema is equally foolish and must be dealt with by someone before a generation of psychiatrists adopt it as doctrine”. Of course, it is Kleinman who adopted Leff’s schema in Patients and Healers, as Leff seems to be the main source of Kleinman’s theorizing regarding the idea that Chinese speakers lack sufficient vocabulary to describe dysphoric affective states. As Beeman pointed out, Leff’s theory separates languages between those with linguistic capacity for explicit, referential terms regarding depression and those with only “relatively undifferentiated” references that employ bodily experiences of emotion. With Leff, the undifferentiated terms of reference are evidence of the stage of sophistication of a linguistic group, as I already demonstrated in discussion of his views above. Beeman argued, however, that such views are rather naïve accounts of how language gets used, suggesting that Leff failed to understand some of the primary functions of metaphor in language. In fact, Beeman claimed that metaphor is the primary mode of expression for emotion, and with enough local knowledge, the researcher should be able to understand the sophisticated and nuanced use of such

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463 Indeed, Beeman only quotes from two works of Kleinman: Patients and Healers (1980) and “Neurasthenia and Depression” (1982), which was the skeleton of Social Origins.


465 Just to drive the point home, I will quote Kleinman again from another section of Patients and Healers where the undifferentiated aspect of language is referenced. There should be no doubt that he was employing Leff uncritically in that earlier text. See Patents and Healers, p. 148, where he proposes a “schema for Chinese management of dysphoric affective state” that involves “non-specific” terms. He claims, “Chinese reduce the intensity of anxiety, depressive feelings, fears, and the like by keeping them undifferentiated, which helps both to distance them and to focus concern elsewhere”. Emphasis is mine. It seems very hard to believe that anyone would make such a claim, especially regarding a linguistic group that has developed some of the most nuanced uses of language across a wide body of literature, including fiction and poetry. That is not even to mention the nuance that exists in Minnan (閩南語).
metaphor. The criticism and discussion of Leff on language by Lutz and Beeman likely served to inform the model presented in the Kleinman’s chapter, such that the poverty of language claim does not feature prominently.

With respect to *Culture and Depression*, the discussion thus far should leave the reader with the sense that it became expedient to soften some of the explanatory claims originally offered as an account for SJSR as a category of Chinese experience. By 1984, A. Kleinman has distanced himself from Leff and the poverty of language argument, and makes the claim that he intended to suggest that “neurasthenia and depression could be understood as distinctive cultural construals of the same psychobiological state”. While the English language record is clear, he has addressed Chinese colleagues in less pejorative language.

In 1984 Kleinman wrote a paper on somatization that was published in Chinese for a journal covering medical topics outside China and published by Hunan Medical University. There are a couple features of this article that make it worth mentioning here. He begins by framing somatization (躯体化作用) as an evolving process that involves the biological, the psychological, and the social, placing it within the biopsychosocial paradigm. Within that frame, he elaborates the same tripartite conceptualization of acute, subacute, and chronic that appeared after 1982, with the idea that prolonged “illness behavior” (疾病行为) can be transformed into a “sick role” (疾病角色) that is reinforced through a type of “operant conditioning” (条件行为控制学), and this occurs with increased interactions with medical systems that seek a physiological etiology. Even in the absence of disease, this can also become or result from a learned “coping style” (因应模式) that we might call the “somatic style” of responding to and expressing distress (躯体化模式来用应付压力及表达困恼). The patient, however, is conceived as unconsciously (不自觉地扮演) playing out this coping style and should not be misconstrued as feigning illness (诈病). This paradigm is basically compatible with *Social Origins* and it is interesting to see in Chinese

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466 See note 460 above.
468 生, 心, 群, 三方面的演化过程。
469 躯体化模式来用应付压力及表达困恼, 65.
translation, but the conclusion of the paper appears to be novel. There he made two claims that he described as clarifications of misunderstandings about the concept of somatization.

First, he stated that somatization is unrelated to psychoanalysis, on the grounds that “Psychoanalytic theory espouses that subconscious psychological factors are more fundamental than somatic symptoms and that psychological symptoms are transformed into somatic symptoms in a symbolic form”.

He was careful to use the theoretic language of “subconscious” here since he had already claimed that somatization occurs in an “unconscious” manner.

In contrast to psychoanalytic theory, he proposed that somatization, as he used it, be regarded as a descriptive term referring to the simultaneously occurring bio-psycho-social distress, that if intensified and maintained, becomes an “illness behavior”.

I will not dispute his use of language here, as he modified his claim from the prior stance that SJSR is “somatized depression”.

Second, in his final comments he made the statement that investigating somatization certainly does not mean that the diagnosis of SJSR lacks the reliability of depression. After all, SJSR is a codified category with criteria. However, he went on to state that “the two phenomena are superimposed, and it can be said that they are two sides of the same coin, or two different ways of examining the same one object”.

He continued: “clinical depression is one type of psychiatric disease that is related to somatization. And SJSR is one form of manifesting one’s illness experience or illness behavior; that is, it’s a form of somatization. Perhaps depression is primary or secondary to SJSR, but the former is not more fundamental than the latter, nor is it more important. The diagnosis and treatment of illness behavior like SJSR, is equally as important as the diagnosis and treatment of a disease like depression”.

470 趣体化作用与精神分析理论无关。精神分析理论主张潜意识心理因素较躯体症状为基本,心理症状经象征的形式而转化为躯体症状,67. All translations of his text are mine.

471 趣体化作用应视为是一个描述性术语,用来描述同时并存的生理、心理及社会各种困难综合起来如何强化及维持疾患行为的症状,67.

472 I am assuming that the choice of Chinese terminology intentionally refers to “reliability” rather than “validity” here.

473 事实上,这两种现象可说相互重叠,可以看作是同一事物的两面,或是对同一件事物的两种不同的观察方法,67.

474 本文主张,临床所见的抑郁症是与躯体化作用有关的精神疾病的一种,而神经衰弱则是对疾患的体验和疾患行为表现的一种类型(一种躯体化方式)。抑郁症或原发性或继发于神经衰弱,但前者并不比后者更为基本或更为重要。对神经衰弱这样的疾患行为的诊断和治疗,其实是和诊断与治疗抑郁症这样的疾病同样的重要。
The reader should be able to recognize that the disease/illness distinction is maintained in Chinese (疾病 vs. 疾患), and SJSR is framed as illness experience/somatization while depression is a psychiatric disease that is related to somatization. So what does it mean to claim that they are two sides of the same thing? What is that one thing, that one shiwu (事物)? We do not have an answer for this because the claim is amorphously relativistic; after all, at other times he referred to SJSR as a disease as well, owing to its recognition in official manuals.475 This is one of several criticisms raised by the renowned psychiatrist Xu Youxin in response to Kleinman’s Chinese article.476 Kleinman’s original claims in Patients and Healers were very clear that depression as disease is the underlying ontological entity, while the somatized SJSR is the phenomenal experience. For all its problems, at least the original stance was logical and coherent. By 1984, there is no coherent position.

4.6 Neurasthenia Revisited in 1989

By the mid-1980s, the views of SJSR as somatization that I have outlined thus far had become a prevalent model in anthropology and cultural psychology/psychiatry, as evinced by how widely it was cited by subsequent researchers.477 Not all of those can be addressed here.478 Instead, space is better used by summarily looking at the 1989 special issue of Culture, Medicine and Psychiatry that served as a conclusion to that decade as well as a “culmination of a venture” begun by Kleinman and Lin regarding SJSR in Asia.479

Intended to offer “a glimpse of the controversy in Chinese psychiatry about the status of neurasthenia, stimulated in part by publication of Dr. Kleinman’s research findings”, the papers in the 1989 special issue provided some cultural history of neurasthenia, and challenged the effort at “formulating an international classification of mental illnesses as well”.480 The volume is

477 Bibliometric data (Web of Science) indicate that from 1980 to 1988 Patients and Healers and Social Origins had been cited several hundred times across a variety of research literatures.
478 There are a number of examples that might demonstrate how this research orientation was put to use, especially by mid-decade. For just one example see: E.H.B. Lin, W.B. Carter, and A.M. Kleinman, “An Exploration of Somatization among Asian Refugees and Immigrants in Primary Care,” American Journal of Public Health 75, no. 9 (1985): 1080–84.
480 Ibid.
comprised of nine papers, two of which argued unapologetically for the retention and use of SJSR as a clinical category (Young and Yan), while two others argued that it was too early to abandon the category (Zhang and Liu). The volume begins with Lin’s offering of a historical view based on his own experience in Taiwan, Japan, and China. Suzuki addressed the thinking of Morita Masatake and the role Morita therapy played in shifting lay and clinical models from *shinkei suijyaku* (神經衰弱) to *shinkei shitsu* (神經質). Munakata discussed the role of Japanese culture in allowing SJSR, among other categories, to be used as a “disguise” diagnosis that prevents the shock and social stigma of more severe illness like schizophrenia. Rin and Huang described their study of patient and physician understandings of SJSR in Taiwan, demonstrating that most “Western-trained” physicians found the category without validity, while both patients and Chinese medicine physicians believed it to be a valid disease category. Interestingly, ninety percent of patients endorsing SJSR in their Taiwan study did not think brain CAT scans would be helpful in understanding their ills, implying that in the Taiwan context SJSR may not be seen as primarily a disorder with imageable brain pathology. Lastly, Cheung attempted to paint a picture of the “indigenization” process whereby popular booklets, patent medicines, tonics, and folk medicine facilitated widespread ideas about SJSR as a physical ailment that could be talked about without the stigma associated with psychiatric and emotional problems.

With respect to historical background, the special issue does not provide much information beyond what can be found in the two chapters of this project above, with the exception of Liu’s discussion of the role of Soviet and Pavlovian theory regarding SJSR’s physiology. Lin’s

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background of SJSR in the West and Japan is cursory; he also made some statements that are
difficult to corroborate (e.g., that neurasthenia established itself as a major disease in the minds of
the Taiwan public in the late 1940s and early 1950s). For the most part, the issue serves as an
interesting editorial or opinion piece, with some additional, informal studies being reported. Some
claims are clearly incorrect, such as Yan’s statement that “the first article on neurasthenia was
published by Song Ming-tong in 1936 in the Tong Ji Medical Journal”. Still, there are other
aspects of the special issue that are interesting enough to raise again for discussion in Chapter 5
below. Presently, I will conclude this section with a brief look at a response to Kleinman that is
represented by Derson Young (杨德森, Hunan Medical University), as his commentary is repeated
by others.

One of Young’s primary criticisms of Western handling of SJSR, as described thus far, is
the fact that the DSM has variously included, altered, and removed neurasthenia from its pages.
He argues that terminological changes hardly resolve the epistemological difficulties in crafting a
valid psychiatric nosology. For this reason, he is not willing to embrace the early efforts at
diagnosing SJSR patients according to DSM-III descriptions of depressive disorder. Additionally,
Young has offered a sophisticated etiological explanation for neurosis, which describes two
“characteristic features” in the general population—a “low threshold of reaction to and
hypersensitivity in response to weak stimuli” and “easy fatigability” —that make it more or less
likely that certain people will develop certain life problems in the face of stressors. He be
lieves that these constitutional factors, in combination with environmental strain acting on the innate
constitution of individuals, gives rise to neuroses such as neurasthenia subsequent to the nervous
system’s management of stress. That is to say, vulnerable people share a diathesis for certain
neurosis syndromes. His view is an empirical matter that is not without significant interest among
researchers. In any case, the reason for raising Young’s view is to situate his understanding of
“somatization”, which follows below.

As we have already seen, Kleinman stated in his Chinese language article that somatization
is unrelated to psychoanalysis, but he also claimed that SJSR was a manifestation of the somatizing

488 Lin, “Neurasthenia Revisited Its Place in Modern Psychiatry,” 117.
489 Yan, “The Necessity of Retaining the Diagnostic Concept of Neurasthenia,” 139. That this is incorrect has been
clearly demonstrated in Chapter 3 above.
490 Young, “Neurasthenia and Related Problems,” 132.
of psychosocial distress and/or the psychiatric disease state of depression. In response to that position, Young had the following to say. First, physical diseases cause mental changes that are never referred to as “psychologization”. Second, somatization has been categorized for a long time as a defense mechanism whereby patients unprepared to face psychic anxiety or dissonance convert emotional factors into bodily symptoms. Xu Youxin raised this criticism of Kleinman’s position as well when he pointed out that, “It is well known that psychological factors themselves can be converted into somatic/bodily symptoms, and this concept was first raised by S. Freud in the initial stages of his research on Hysteria, which he undertook almost a century ago”. It is therefore wrongheaded to use “somatization” as a term to stand-in for “somatic symptom” as such uses only cause confusion. Third, mental tension is known to cause a variety of somatic symptoms such as tachycardia and headaches, which are the direct result of stress and do not warrant the claim that they are a somatization of something else. Fourth, only in some cases is “mental tension or the desire for secondary gain transformed into somatic symptoms through semi-conscious somatization or conversion processes”. Of course, there are also unconscious processes, but it is “inappropriate to consider all somatic symptoms in mental illness as psychogenic. Regrettably, in the investigation of somatization, some authors have tried to include the whole into the part”. In like manner, Xu Youxin concluded with a rejection of Kleinman’s notion that somatization is merely a descriptive term. Rather, Xu argued that “it is a mode of explanation that considers a patient’s physical symptoms to be a conversion of their psychological issues, and of course not all physicians chose to adopt such an explanatory framework for their patients’ experiences”. This stance of Xu’s served as a preliminary repudiation of the attempt to re-frame

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491 众所周知,心理的东西本身可以转换成为躯体症状这个概念是精神分析创始人 S. Freud 首先提出来的,那还是在他研究歇斯底里的初期阶段,距今已经将近一个世纪了; see, Xu Youxin (许又新), 130.

492 This is an important point. So far, I have not addressed the etymology of the term “somatization” or 躯体化, but as should be clear, these terms require that there is an antecedent “something” that is undergoing the “-ization” or “-化”. Young’s point is that since we know that stress causes physical symptoms of many sorts, it does not make sense to say that the symptoms are a bodily-transformation of the stress, or a 躯体 - 化. Rather, the symptoms are a causal consequence of the physiology of the stress. This is the fundamental point of divergence in explanatory models of SJSR.

493 Young, “Neurasthenia and Related Problems,” 136. At this point, Young cites Kleinman’s 1984 Chinese language publication discussed above.

494 Xu Youxin (许又新), 130, 因此,应该看到,躯体化并不是一个描述性术语。毋宁说,躯体化是医生的一种解释模式(4),它把病人的某些躯体症状解释为由病人的某种心理转变而来。当然,由于医生们的观点分歧,远不是所有医生都采用这种特殊的解释模式,作者就是不采用这种模式的医生中的一个。
SJSR patient experiences as instances of clinical depression manifesting bodily. As will be seen in subsequent chapters, resisting this attempt at redefinition is no simple task.

4.7 Rethinking Psychiatry and Conclusion

The 1988 publication of *Rethinking Psychiatry* did not offer any new approach to SJSR. However, it did call on psychiatric researchers to engage in a critical self-reflection of how they conceptualize the experience of patients. Cultural and comparative studies are rightly seen as “an antidote to professional ethnocentrism”, and psychiatry’s “central assumptions and paradigms” are said to be exposed through the process of cross-cultural comparison. As it is not my aim to take issue with the larger anthropological approach of Kleinman, with most of which I agree, I ignore most of the theoretical discussion of the book. Instead, I point out that he appears not to recognize his own instances of ethnocentrism and assumption when it comes to SJSR. In that regard, I only address theory in one instance at the end of this discussion.

Seven pages into this monograph we once more are provided with a case description of an SJSR patient from 1980 (Mrs. Lin), and her presentation appears typical. However, he concluded that, for the anthropologist, her problem seems more like the consequences of demoralization and life distress than it does depression. The obvious question, then, is why diagnose depression? If “a psychiatric diagnosis is an interpretation of a person’s experience”, then why interpret her experience as the DSM category of depression specifically? Of course it may be the case that the severe disease condition, recognized even before Burton, is what best describes the patient’s experience. In that case, then perhaps she should be rediagnosed as a “Chinese depressive” as he has done numerous times before (and says as much on p. 13). In such a case, one should conclude that SJSR represents “culturally shaped illness experience underwritten by the disease depression”. The problem is that Kleinman repudiated such a view only pages later when criticizing the often held idea that the “biology of depression and anxiety disorders underwrites the inner form of these disorders, but cultural beliefs and values so shape the ‘expression’ of the disease that the bodily complaints come to ‘mask’ the real psychiatric disease ‘underlying’

496 Ibid., 7. Emphasis in original.
them”.499 Surely, “underlying” is not different from “underwrites”, and I have made it clear from the previous sections that he claimed numerous times that depression is the underlying disease in SJSR. Furthermore, he continued to claim to “have shown that headaches, dizziness, and lack of energy form a symptom cluster in ancient Chinese society and in contemporary Taiwan and China, which is the core neurasthenic illness behavior associated with mixed depressive and anxiety disorders”. 500 However, re-diagnosing one hundred percent of SJSR patients with a category from DSM-III, to the consternation of their Chinese physicians, does not constitute a demonstration of anything other than the fact that there are competing nosologies at play in different parts of the world. It seems apparent that many SJSR patients experience symptoms of “psychophysiological arousal and the multiform somatic effects of stress”, but it is not clear that they are “selectively perceiving, labeling, and communicating them” to fit some cultural template or as a consequence of failure to recognize affective symptoms.501 This appears to be the fundamental question at hand.

Let me reformulate what I see as a shortcoming of this text. In the introduction, there is much discussion about the importance for psychiatry in avoiding invalid interpretations of patient experiences, with proper understandings of cultural context serving to buffer against committing such mistakes. One representative example of such an error is labeling as hallucination a normative cultural experience, such as when an indigenous North American hears the voice of a deceased spouse.502 This phenomenon may very well be part of the normative processes of bereavement. The implication is that “the term ‘hallucination,’ when used in its clinical sense to mean an abnormal percept, is an invalid interpretation for these individuals”.503 In other words, a person can have the perception of a deceased spouse speaking to them, in the absence of any physical stimulus, as a consequence of the cultural expectation that such speaking will occur. In this case, we are told that the psychiatrist should not label such phenomena as an abnormal percept or a hallucination.504 This raises two related, important criticisms.

499 Ibid., 25.
500 Ibid., 41.
501 Ibid., Emphasis mine.
503 Ibid., 12.
504 Anna Castelnovo et al., “Post-Bereavement Hallucinatory Experiences: A Critical Overview of Population and Clinical Studies,” Journal of Affective Disorders 186 (November 1, 2015): 266–74, https://doi.org/10.1016/j.jad.2015.07.032. This phenomenon may be more common than we realize. It is still
First, on the very same page, is the description of a Chinese patient with a culturally well-understood syndrome that carries certain expected symptoms, but he chooses to apply a DSM diagnosis to the patient, which both the patient and her Chinese physicians do not endorse. Insofar as the invalid labeling of the Native American’s bereavement constitutes a category fallacy, the rediagnosing of SJSR patients certainly seems to raise the same question of the validity of the “depressive” label.

Second, it is an empirical question as to whether the Native American has spontaneous temporal lobe activity in the absence of external stimulus, which is then interpreted as the voice of the deceased, or if they misinterpret external stimuli as the voice. The difference is actually quite significant. If the grieving person does not merely misinterpret external stimuli, but actually has the experience/perception of a voice, with the spontaneous brain activity that would have occurred if there were external stimuli, then it means that the role of cultural expectation and belief is far more important than even Kleinman’s cultural approach implies. It would mean that the expectation/belief is a causal force of the spontaneous brain activity that is perceived as voices. In such a case, Kleinman would not claim that the Native American’s perception “selects out and lumps together” the experiences of the deceased voice. The perception is the very experience of the voice. The culturally informed belief gives rise to the perception causally. In like manner, why does Kleinman not argue that Mrs. Lin’s perception is the symptom? Instead he argues that her “perception of her symptoms selects out and lumps together those symptoms that are familiar and salient to her, namely the ones that fit the popular blueprint of neurasthenia”.\footnote{Ibid., 13.} Why is it that in one case the perception would be the symptom/experience, while in the other case the perception selects out and lumps the salient symptoms? Because, as Kleinman stated, “For myself, the North American psychiatrist who interviewed Mrs. Lin, neurasthenia was not a diagnostic possibility”\footnote{Ibid.} That is despite the fact that the category existed in ICD at the time. In any case, this tension regarding the individual’s perception “giving rise to” versus “selecting-out” experiences serves to highlight that Rethinking Psychiatry does not go far enough in conceptualizing SJSR and the power of culture to affect the brain generally.

\footnote{hallucinatory; it is just not psychotic. Whether it is culturally specific or more common across cultures, my argument remains the same. I think the point is that the expectation or even desire to hear the loved-one can causally affect the brain such that there is percept without physical stimulus from outside.}
In the previous pages, I have attempted to outline for the reader a process of Western academic engagement with SJSR as a clinical category that began just before 1980. It seems that Kleinman’s original aim in calling on his colleagues to work at the interface of anthropology and psychiatry was motivated by the desire not to overlook the contributions of culture in the experience of patients. His disagreement with Singer was based on the notion that Singer failed to see that patient presentations differ on the basis of the cultural backgrounds that give rise to experience and mold the manner in which symptoms take shape. As can be seen from the literature produced, however, there is a great irony at play. The attempt to employ anthropology in the study of SJSR appears to have led to the very types of cultural impositions for which anthropology has historically been criticized. In this case, SJSR was viewed as being the result of Asian suppression and denial of affect, the linguistic incapacity for emotional descriptions, and the need to avoid stigma by using clinical categories that failed to delineate the real underlying reasons for patient distress. By the mid-1980s, it appears that some of these presuppositions and conclusions were less emphasized, but the claims had already reached Chinese psychiatrists who began to take issue with what was being claimed. In the next chapter, I continue this examination by looking at the work that was to follow this original model of SJSR as somatized depression.
Chapter 5: *Shenjing Shuairuo Survives into the Twenty-First Century*

“Modes of healing and culturally specific beliefs about how to achieve mental health can be lost to humanity with the grim finality of an animal or plant lapsing into extinction. And like those plants and animals, the diversity in the human understanding of the mind can disappear before we’ve truly comprehended its value.”

The materials that monopolized discussion in the previous chapter served primarily to demonstrate just how contentious was the intellectual orientation of the NCCP in its early interpretations of SJSR. Some of the explicit claims that were documented in that chapter have yet to be recanted by the originators, despite no longer being voiced. Nevertheless, the period marked a turning point in both Western and Chinese views of neurasthenia, and the debates arising from the literature were later called “the neurasthenia-depression controversy.”

The 1990s and the first decade of the twenty-first century saw an interesting transition from the stance-taking that occurred earlier. For example, by the mid-eighties, opinions seemed to be very much split between the two camps, with one side arguing for the validity of SJSR as a disease category that was epistemically (and ontologically) distinct from depression, while the other side argued that SJSR was a local illness experience in China that facilitated the manifestation of dysphoric affect or was itself underlain by depression. In the subsequent decades, opinions and interpretations of research findings were much more nuanced, with an apparent recognition that it was difficult to argue for an either/or scenario when it came to SJSR. Part of the reason for this change was that the Chinese classification system modified its assessment criteria for the disorder, narrowing the population that could receive the diagnosis. Other reasons include changes to both the ICD and the DSM. Still, there were instances where the forced dichotomy continued to raise its head and researchers occasionally took sides.

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509 If those vested in this issue prefer retrospectively to reinterpret their position differently than I state it here, I suggest they go back and reread the literature discussed in the previous chapter. Recall the original comments about being “convinced of the diagnosis of depression” and Chinese language lacking terms for emotional differentiation, among other explicit claims. I have not misunderstood the original position; the position was modified, which is discussed in this chapter.
My aim in the following pages is to continue with a consideration of the ways in which SJSR was undergoing reconstruction in the decade following Kleinman’s original reduction of it to depression. In the 1990s, there was engagement with SJSR from a number of fronts. One of these was a reexamination of the increasingly entrenched Western idea of Chinese somatization, while another consisted of a comparison of SJSR with ICD and DSM categories in a search for equivalencies. One of the key proponents of the NCCP and interpreters of SJSR in the nineties was Hong Kong psychiatrist, Sing Lee, who recognized only in part the role of the NCCP in the transformation of SJSR at the turn of the century. In the first decade of 2000, there was a hodgepodge of commentary about SJSR, demonstrating only that not much progress had been made. I take up each decade in turn. First, however, I briefly offer some background to the changing diagnostic systems in place from the end of the 1980s, in order to situate the attempts to frame SJSR within those new diagnostic systems.

5.1 Changing Diagnostic Systems on the World Scene

Let me begin by stating that it is beyond the scope of this project to undertake a detailed examination of all the numerous forces that gave rise to the publications and revisions of the various diagnostic systems through which SJSR has been examined, critiqued, and interpreted. Instead, I want to make clear how the classification systems are relevant, specifically with regard to the research into SJSR that has taken place since 1980. I start briefly with the ICD, and follow with the DSM and the CCMD.

The World Health Organization was officially founded in April of 1948, and the First World Health Assembly took place in July of that same year. I remind the reader that the creation of the WHO was the result of a vote two years earlier in New York in response to a proposal by the delegations from China (at the time, this was the Republic of China) and Brazil regarding the need to establish such an organization. At that time, the WHO took on the responsibility of publishing and updating the ICD, which would be a continuation of a long-standing international effort at documenting causes of death. With the founding, morbidity was added to the documentation of mortality, and that version, undertaken by the new WHO, would be published

as ICD-6.\textsuperscript{511} “Nervousness with debility” fell under “ill-defined diseases” while “[p]sychoneurosis with somatic symptoms” and “asthenic reaction” were among the diagnostic groups listed. This practice continued through ICD-7 and was later modified with the separation of psychoses and neurosis in ICD-8 in 1965, with neurasthenia being listed as a neurotic disorder.

To the present day, neurasthenia has continued to be listed as a neurotic disorder, but other classes of disorders have been added to the system, including chronic fatigue syndrome (CFS), somatization disorder, somatoform autonomic dysfunction, unspecified somatoform disorder, among others. Some of these changes are listed for reference in Table 4. The history and changes of the ICD system are very complicated and cumbersome. I mention them here so that the reader can understand the various directions that SJSR researchers have taken since the mid-1980s in an attempt to explain what is “really” happening in the Chinese context. I return to this topic after briefly addressing the DSM and the CCMD.

The first edition of the DSM, published in 1952, catalogued a “psychophysiological nervous system reaction”, which “term includes many cases formerly called neurasthenia”.\textsuperscript{512} At that time, it was conceived as a psychophysiological asthenic reaction with fatigue as the predominant complaint. It was understood that the disorder could also have visceral symptoms and could represent a conversion reaction or an anxiety reaction. Neurasthenia was not formally a diagnostic category. In the second edition of the DSM, published in 1968, neurasthenic neurosis was (re)introduced as a “condition characterized by complaints of chronic weakness, easy fatigability, and sometimes exhaustion”.\textsuperscript{513} It was considered different from both anxiety neurosis and psychophysiological disorders in the predominant complaint.\textsuperscript{514} It was also to be distinguished from depression in the moderateness of the associated depression and its chronicity.

\textsuperscript{513} American Psychiatric Association, \textit{Diagnostic and Statistical Manual of Mental Disorders}, 40.
\textsuperscript{514} It is hard to understand how the “general fatigue” of DSM-I is different from the “chronic weakness and easy fatigability” of DSM-II. The former was a “psychophysiological nervous system reaction” while the latter was “neurasthenic neurosis”. 
### Table 4: Historical versions of ICD and their diagnostic categories pertaining to neurasthenia

<table>
<thead>
<tr>
<th>Version / Date</th>
<th>Relevant categories pertaining to neurasthenia</th>
</tr>
</thead>
</table>
| ICD-6 / 1948   | - Nervousness, debility, undue fatigue, and depression  
                 - Psychoneurosis with somatic symptoms by organ system  
                 - Psychoneurosis with somatic symptoms and asthenic reaction |
| ICD-7 / 1955   | - Same as above |
| ICD-8 / 1965   | - Nervousness, debility, and undue fatigue  
                 - Separation of psychoses and neuroses  
                 - Anxiety neurosis, depressive neurosis, and **neurasthenia** listed as distinct neurotic disorder entities  
                 - Encephalitis, myelitis and encephalomyelitis listed |
| ICD-9 / 1975   | - Fatigue listed as a general symptom with a code  
                 - Neuroses are refined as neurotic disorders. Anxiety states, neurotic depression have their own coding.  
                 - **Neurasthenia** is listed as a subcategory of neurotic disorders.  
                 - “Other neurotic disorders” lists “somatization disorder”.  
                 - Benign myalgic encephalomyelitis named.  
                 - Chronic fatigue syndrome (CFS) added in 1988 (code 780.71). |
| ICD-10 / 1990  | - Malaise and fatigue listed as “general symptom and sign” with codes.  
                 - Post-viral fatigue syndrome listed as a brain disorder with sub-heading of benign myalgic encephalomyelitis.  
                 - CFS indexed to “benign myalgic encephalomyelitis”.  
                 - “Neurotic, stress-related and somatoform disorders” (F40-F48) includes somatoform disorders and **neurasthenia**  
                 - F45.0 Somatization disorder  
                 - F45.1 Undifferentiated somatoform disorder  
                 - F45.2 Hypochondriacal disorder  
                 - F45.3 Somatoform autonomic dysfunction  
                 - F45.4 Persistent somatoform pain disorder  
                 - F45.8 Other somatoform disorders  
                 - F45.9 Somatoform disorder, unspecified  
                 - F48 Other neurotic disorders  
                 - F48.0 **Neurasthenia** |

By 1980, DSM-III officially removed neurasthenia as a diagnostic category but indexed the term with a reference to the category of “Dysthymic Disorder (or Depressive Neurosis)”, which was characterized by a chronic disturbance of mood. The revised DSM-III continued this

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organization when it was published in 1987. In addition to the removal of neurasthenia, DSM-III added a specific section on somatoform disorders, the essential features of which “are physical symptoms suggesting physical disorder (hence, somatoform) for which there are no demonstrable organic findings or known physiological mechanisms and for which there is positive evidence, or a strong presumption, that the symptoms are linked to psychological factors or conflicts”. The fourth edition of the DSM was published in 1994, at which point neurasthenia was reintroduced and reduced to a translation of SJSR, and appeared in the appendix glossary of “culture bound syndromes”, as was mentioned and cited in the introduction. The organization of somatoform disorders continued in DSM-IV, a list of which can be seen in Figure 18 below.

**Somatization Disorder** (historically referred to as hysteria or Briquet’s syndrome) is a polysymptomatic disorder that begins before age 30 years, extends over a period of years, and is characterized by a combination of pain, gastrointestinal, sexual, and pseudoneurological symptoms.

**Undifferentiated Somatoform Disorder** is characterized by unexplained physical complaints, lasting at least 6 months, that are below the threshold for a diagnosis of Somatization Disorder.

**Conversion Disorder** involves unexplained symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition. Psychological factors are judged to be associated with the symptoms or deficits.

**Pain Disorder** is characterized by pain as the predominant focus of clinical attention. In addition, psychological factors are judged to have an important role in its onset, severity, exacerbation, or maintenance.

**Hypochondriasis** is the preoccupation with the fear of having, or the idea that one has, a serious disease based on the person’s misinterpretation of bodily symptoms or bodily functions.

**Body Dysmorphic Disorder** is the preoccupation with an imagined or exaggerated defect in physical appearance.

**Somatoform Disorder Not Otherwise Specified** is included for coding disorders with somatoform symptoms that do not meet the criteria for any of the specific Somatoform Disorders.

![Figure 18: DSM-IV Somatoform Disorders](image)

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517 *DSM-III-R*, 241; Somatoform Disorders section of Chapter 3. Kleinman hesitated to use this category in 1980, opting to rediagnose nearly all SJSR patients as having depression.

518 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 445.
These categories and the listing of neurasthenia in the Culture-Bound Glossary were to continue with the Text Revision of DSM-IV in 2000; however, at that time, chronic fatigue syndrome (CFS) was not listed as a distinct category as it was in the ICD. Instead, unspecified somatoform disorder was described as being characterized by complaints of chronic fatigue. Other writers have addressed the history and intellectual challenges that under-gird the various changes in the DSM nosology, and so these are not repeated here. It is worth noticing, however, that the basic categories in the DSM followed the ICD changes at least nominally, with the exception of excluding neurasthenia from the main body of the diagnostic text after 1980. A few words about the CCMD should be said here.

Recall from the last chapter that the earliest drafts of the CCMD appear to have begun with the first nationwide conference on psychiatric disorders held in 1958. The second national conference in 1978 revised the 1959 draft and produced the 1979 “Draft of Classification of Mental Disorders” that was to constitute the first edition of the CCMD. This process also roughly coincided with the World Health Organization’s adoption of the ninth edition of the ICD (1975). Around the same time, the American Psychiatric Association published DSM-III in 1980. For ease of comparison, these dates of publication can be compared in Table 5.

Table 5: Comparison of publication dates for ICD, DSM, and CCMD

<table>
<thead>
<tr>
<th>ICD</th>
<th>DSM</th>
<th>CCMD</th>
</tr>
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<tbody>
<tr>
<td>ICD-6 (1948)</td>
<td>DSM-I (1952)</td>
<td>---</td>
</tr>
<tr>
<td>ICD-7 (1955)</td>
<td>---</td>
<td>First draft, not officially used (1958)</td>
</tr>
<tr>
<td>ICD-8 (1965)</td>
<td>DSM-II (1968)</td>
<td>---</td>
</tr>
<tr>
<td>ICD-9 (1975)</td>
<td>---</td>
<td>CCMD-I (1978)</td>
</tr>
<tr>
<td>---</td>
<td>DSM-III (1980)</td>
<td>---</td>
</tr>
<tr>
<td>---</td>
<td>DSM-III-Revised (1987)</td>
<td>---</td>
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</tbody>
</table>

In 1986 Professor Derson Young headed a committee to revise the CCMD. Among the many goals of the revision were the aims of approximating ICD-10 and DSM-III in a manner that was grounded in ongoing research in China and around the world, with consideration given to cultural issues within China that might not be reflected in American or international classifications. Upon its completion in 1989, CCMD-2 was used in a field trial in China, comparing the Chinese classifications with DSM-III-R diagnostic differences across Chinese patients. From a final sample of 254 patients (209 inpatient, 45 outpatient) from fifteen hospitals across China, researchers came to some interesting conclusions. The results of the trial demonstrated that CCMD-2 was nearly indistinguishable in its inter-user diagnostic reliability when compared with DSM-III-R across almost all psychiatric diagnoses and could be considered as an interchangeable classification system. Unsurprisingly, however, there were a small number of cases where diagnostic discrepancy did exist. By CCMD-2 criteria, five patients where labeled with SJSR; using DSM criteria, these five patients were formulated as undifferentiated somatoform disorder (one patient), generalized anxiety disorder (one patient), or no diagnosis was found to be suitable (three patients).\textsuperscript{520} This discrepancy gets at the very heart of the entire controversy regarding SJSR in the Chinese context, especially since neurasthenia would have been a diagnostic option if the ICD had been used.

The researchers involved in the field trial, still sensitive to Kleinman’s 1980 re-diagnosing eighty-seven percent of SJSR patients with depression (Social Origins), readily admitted that SJSR had been overused as a diagnosis prior to the introduction of DSM-III into China.\textsuperscript{521} However, and perhaps most importantly of all, they rejected the notion that SJSR lacked validity as a concept merely due to its being expunged from the DSM. They pointed out in their publication of the study results that none of the patients diagnosed with SJSR using CCMD-2 met criteria for DSM depression. Focusing on this fact, they turned to the issue of unspecified somatoform disorder (USD) in the DSM and the growing American interest in chronic fatigue syndrome (CFS), which had also been listed in the ICD. They raised the question of whether some SJSR patient diagnoses

\textsuperscript{520} Details of the study can be found here. Y.P. Zheng et al., “Comparative Study of Diagnostic Systems: Chinese Classification of Mental Disorders-Second Edition versus DSM-III-R,” Comprehensive Psychiatry 35, no. 6 (December 1994): 441–49. In addition to differences regarding SJSR, there were patients diagnosed with qi-gong induced dissociation, which was not a category in the DSM. This disorder is beyond the scope of our discussion, but there have been a number of cases of qi-gong induced psychotic-like episodes documented in American cities since the 1990’s.

\textsuperscript{521} Ibid., 445.
might be equivalent to either of these categories, implying that the American Psychiatric Association had merely made nominal changes to the DSM; that is, the APA had expunged neurasthenia but introduced unspecified somatoform disorder. Even so, there were still cases that met neither USD nor CFS criteria. Much of the literature in the 1990s was focused on just these issues.

5.2 Reframing the SJSR Diagnosis in the 1990s

As academics continued to consider the meaning of SJSR in the 1990s, a central question persisted regarding the concept of somatization. In 2015 we can continue to find criticism of the concept as applied to Asian persons when we read that “a received opinion in medical literature holds that Asians are prone to present psychiatric problems as physical complaints—depression as back ache. Implying as it does that Asians lack a proper understanding of what ails them or, if they do understand, hesitate to call it by its right name, this dogma enshrines prejudices and misreadings as medical facts”.

Some of the writings that helped to entrench such ideas were already discussed in detail in the previous chapter. In the years following the publication of those writings, there was no shortage of efforts to bring some clarity to the concept of somatization. Continued reflection on the issue of somatization made clear that, with the publication of DSM-III (and subsequent editions), somatic symptom presentations were no longer to be viewed as symptom constellations that clearly pointed to some other underlying diagnosable issue. Instead, the DSM began to list somatization phenomena as separate diagnosable entities themselves. These categories are listed above as discrete diagnostic entities, whereas in the past, patients were diagnosed on the basis of what was considered the etiology underlying any given form of somatic presentation. This change along with publications claiming somatization as a culturally particular phenomenon of help-seeking led researchers to examine how commonly patients presented to their providers with bodily complaints. By the end of the 1980s, it increasingly was understood that

522 Stewart Justman, The Nocebo Effect: Overdiagnosis and Its Costs (Springer, 2016), 1. I will point out to the reader that the author of this book is critical of such cultural stereotyping specifically and the medicalization of everyday life problems generally.

somatic presentations were ubiquitous, including within Western countries. The question then became one of clarifying the variety of manner in which patients tended to present physical complaints in the absence of any recognizable lesion. Recall from Chapter 2 that absence of lesion was the historical way of formulating the idea of “functional” disorder. In such cases, there appeared to be a problem with the physical functioning of some part of the body without any obvious or identifiable lesion to account for the functional change. I pointed out earlier that somatization was defined by Kleinman as “the expression of personal and social distress in an idiom of bodily complaints with medical help seeking”. The bodily complaints and medical help-seeking could arise from a number of factors, as Katon and Kleinman addressed more thoroughly elsewhere and as can be seen in Table 6.

Table 6: Five definitions of somatization from Katon and Kleinman

<table>
<thead>
<tr>
<th>Definition</th>
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<tbody>
<tr>
<td>1. The selective focus on the somatic components of a psychological syndrome (depression, panic disorder) that has cognitive, affective, and somatic symptoms.</td>
</tr>
<tr>
<td>2. The amplification of somatic symptoms in a patient with organic illness for primary gain, i.e., the use of somatic symptoms as a defense against underlying dysphoric affect or intrapsychic conflict, or secondary gain, i.e., the interpersonal or environmental advantage supplied by the symptoms.</td>
</tr>
<tr>
<td>3. The use of somatic symptoms in the absence of any demonstrable organic disease to avoid dysphoric affect or intrapsychic conflict or consciously or unconsciously to manipulate the social environment for personal gain.</td>
</tr>
<tr>
<td>4. The selective focus on psycho-physiologic symptoms such as migraine headaches, peptic ulcers, or back pain secondary to stressful life events with denial or minimization of life problems that have precipitated or exacerbated the illness.</td>
</tr>
<tr>
<td>5. The expression of physical complaints as a culturally sanctioned idiom of distress to indirectly implicate family, work, school, financial, or other social problems.</td>
</tr>
</tbody>
</table>


525 Obvious examples are stomach aches, constipation, headache, etc., in the absence of any pathology. With modern medical technology, search for lesions is even more thorough than mere physical examination.


If we think about this list with regard to the attempt to apply it to claims about Chinese somatization, we find that it is overly broad for two reasons. First, SJSR patients that present with difficulties in concentration or memory (cognitive symptoms) are not included in (1). Second, amplification of symptoms from “organic illness” rules out SJSR patients who lack bodily illness, eliminating (2). Items (3–5) are the real issues regarding SJSR, where we are interested in patients selectively presenting bodily symptoms to the exclusion of any psychosocial attribution. The question now becomes one of carefully delineating the illness behavior of a patient presenting with bodily symptoms in the absence of lesion; in other words, does the patient refuse to allow for any psychosocial interpretation when queried, or will they be open to attributing some of their experience to such factors? In the primary care context, Bridges and Goldberg determined in 1985 that we might do well to think of somatization as being at least separable into those who were “true somatizers” as opposed to “facultative somatizers”. That is to say that the true somatizer was one whose consulting behavior (seeing the doctor) was specifically for somatic complaints without psychological symptoms, who attributed the symptoms only to physical causes, and had been determined to meet criteria for psychiatric diagnosis without any physiological explanation that could account for the somatic complaints. On the other hand, facultative somatizers were those whose consulting behavior was for somatic complaints (not psychological) and no physiological cause was found, but the patient did not attribute symptoms only to physical causes when interviewed by a psychiatrist. In other words, their somatic presentation was facultative as they were open to psychosocial explanations that might account for their symptoms.

Kirmayer, who we discussed in the previous chapter, continued writing on somatization in the 1990s, and attempted further to differentiate somatization as illness behavior in primary care along the lines of clarification initiated by Bridges and Goldberg. Working with Anglophone and Francophone Canadians, he operationalized somatization with four criteria summarized and simplified here: (1) meet criteria for DSM diagnosis, (2) present only somatic symptoms, (3) make exclusively somatic attributions for the symptoms, and (4) “when asked directly, reject nerves or worries as a possible cause of their problems”.

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528 As we have seen in Chapter 3, cognitive symptoms have always been considered to play a role in SJSR. This is further addressed later in this chapter.
529 Bridges and Goldberg, “Somatic Presentation of DSM III Psychiatric Disorders in Primary Care,” 564.
the true somatizers; those who meet (1–3), but are open to psychosocial attributions when asked, correspond to facultative somatizers. A third group consists of those who meet (1–2), but instead of conforming to (3), they also volunteer psychosocial explanations in the course of the interview. This third group he called “initial somatizers”, as they present initially with somatic complaints, but then offer psychological explanations of their own accord. The significance of this delineation is to point out that illness behavior unfolds in a variety of ways depending on the sociocultural/learned expectations for how one ought to present oneself to a health care provider.531 The illness behavior of somatization proved to be extremely common and quite varied.

In the Chinese context, some of the more vocal critiques about culture-group somatization seem to have fallen on deaf ears. In 1992 Yuko Kawanishi’s “Somatization of Asians: An Artifact of Western Medicalization?” took aim at Kleinman’s early work in an attempt to demonstrate from the literature that a tendency to present in a clinic with somatic symptoms did not equate with the claim that Asians somatize. Her convincing argument rests in part on the fact that past research was based primarily on ethnographic studies of small groups of patients, limiting their generalizability and perhaps relying on preconceived notions about cultural traits. Furthermore, she cited larger studies that directly conflicted with the idea that Asians presented with somatic complaints disproportionately more than Western patients.532 This is to say that, while it may be a cultural phenomenon that Chinese patients tend to present themselves to physicians with initial complaints pertaining to the body, it is not clear that such presentations indicate unawareness of underlying emotional or psychological distress or unwillingness to endorse such experiences. As even Kleinman’s work from 1980 demonstrated, many of his patients would be categorized as facultative somatizers. Others may have been initial somatizers. Still, others refused to endorse psychological symptoms; all such situations are consistent with Kirmayer’s findings with Anglophone and Francophone Canadians. Kawanishi concluded that the Asian-somatization thesis was likely the result of racial stereotyping, limitations of Western psychotherapy, and a dichotomous view of the mind-body in medicalized, Western society.533

531 As would be expected, there were also patients whose initial presentation included psychosocial problems rather than bodily complaints.
533 Ibid., 30.
Writing in 1995, Psychologist Fanny Cheung reminded readers, in “Facts and Myths about Somatization among the Chinese”, that the explanatory concepts put forth to justify the idea that Chinese tend to somatize their problems basically fell into three categories of assumption about Chinese patients: (1) “Denial, suppression, or repression of emotions”, (2) “Lack of vocabulary or semantic network to express affective states”, and (3) “Lack of differentiation between mind and body.” I demonstrated previously that her criticisms here are correct in pointing out exactly these premises, which served as the intellectual foundation of the NCCP’s initial understandings of SJSR as somatized depression. Nevertheless, most writers appear to ignore this very ill-informed and dubious starting position. Her conclusions seem to suggest that thinking about Chinese somatization had simply moved beyond its original formulations with increasing recognition that Chinese patients, along with patients in other parts of the world, are able to present and talk about psychological symptoms quite fluently when probed directly. Instead of being viewed as a culture-specific tendency, it seems that researchers had come to appreciate that somatization is universal, and Chinese patients also participate in the facultative, initial, and true somatizer forms of symptom presentation.

In the midst of the effortful investigations into somatization, the psychological construct of “alexithymia” also came into play in the mid-1990s. Classically, alexithymia served as a personality construct used to describe the inability of certain patients to describe emotional experiences. Working with a study population in Toronto in 1995, Dion found that Chinese speakers in Toronto scored significantly higher on rating scales for alexithymia when compared to native English speakers or non-native English speakers of European background. She hypothesized that the finding could be explained by the existence of “sociocultural processes characteristic of Chinese culture. According to this sociocultural explanation, the personality trait of alexithymia is fostered among ethnic Chinese because Chinese culture strongly encourages a somatic idiom for construing expressing and describing one’s emotional states . . . as an alternative to the psychological idiom prominent in ‘Anglo’ and Western European segments of Canadian and

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535 In philosophical logic there is a fallacy known as the “argumentum ad logicum” that describes the fallacy of dismissing a correct conclusion because of the erroneous manner in which it was reached. I grant that it would itself be a fallacy to dismiss the conclusions of Kleinman’s early work merely on the basis that the reasoning and processes for reaching the conclusions were themselves egregiously erroneous. The means do not disprove the end. Still, the faulty process should make the conclusion suspect.
American cultures.\textsuperscript{536} Claiming that Chinese persons are alexithymic as a consequence of their culture resonated with some of the NCCP claims from previous years, but research in the coming decade would show that the construct of alexithymia needed further parsing. This is briefly addressed in the final chapter.\textsuperscript{537}

Reflecting on his prior work, Kleinman wrote in 1995 that \textit{Patients and Healers} was a “critique of biomedicine for its ethnocentrism, its reductionism, its essentialism, and its failure to engage the life world of patients”.\textsuperscript{538} The obvious irony is that \textit{Patients and Healers} was itself a paradigmatic example of ethnocentrism, reductionism, and essentialism. Its contribution, however, was to emphasize the importance of engaging the life-worlds of patients. Further reflection on those life-worlds led Kleinman significantly to modify his view on somatization, with a recognition that his earlier formulations of the concept were “too tied to a disease/illness distinction, which becomes less and less tenable”.\textsuperscript{539} Another irony: such over-reliance on the disease/illness distinction was the very criticism leveled at Kleinman by Derson Young two years earlier, and which Kleinman dismissed as Young’s ignorance of anthropology and cultural psychiatry.\textsuperscript{540} Additionally, Kleinman also accused Young of denying that changes in “society and worldwide” contributed to mental illness, despite Young’s having written just the opposite regarding neurotic disorders.\textsuperscript{541} Nevertheless, with Kleinman’s changed view of somatization, there was no longer the need to view SJSR complaints as arising from a “cognitive coping process”, and he began to believe that “somatization seems normative and often normal: it is not so much a substitution for something more basic as it is a basic way of being-in-the-world”.\textsuperscript{542} As such, his “study of somatization suggests that the body can be a vehicle for experiencing, interpreting, and communicating about emotion and social issues, that the person’s experience, interpretation, and expression of bodily functions is negotiated in interpersonal relations. Somatic idioms of distress

\begin{thebibliography}{99}
\bibitem{kleinman1995} Specifically, the concept of “externally oriented thinking” served to complicate the alexithymia construct. This is discussed in Chapter 6 below.
\bibitem{young1993} Ibid.
\bibitem{yang1984a} Ibid.
\end{thebibliography}
also indicate that in some nontrivial sense the body feels and expresses social problems”\(^{543}\). Such a view of somatization, according to Kleinman, marks the beginning of a shift away from viewing clinical depression as a disease and toward seeing it as lying within a broader context of social suffering. It should be obvious that with such a view of somatization, and the shift away from viewing depression as a disease, no philosophical ground remains for any claim regarding the hierarchy or ontological priority of depression, somatic complaint, or SJSR. The increasingly relativist intellectual position translated into Kleinman’s work becoming ever less clinical in nature. Still, the view of somatization and SJSR that were put forward in the 1980s were spread broadly enough, and the controversy had become significant enough, that the numerous researchers involved continued to investigate the subjects despite whatever changes in view Kleinman professed. As intellectuals grew increasingly dissatisfied with the “Asians somatize” view, as well as with the idea that neurasthenia was “simply a somatized form of anxiety or depressive disorder”, some clarity had to be sought regarding where exactly the various nosologies were getting things right and where they were getting it wrong.\(^{544}\)

Neurasthenia’s continued place in ICD-10 was suggested to be a result of the fact that the category was not easily reducible to other labels. The ICD-10 book of clinical descriptions explained the following:

Although omitted from some classification systems, neurasthenia has been retained as a category in ICD-10, since this diagnosis is still regularly and widely used in a number of countries. Research carried out in various settings has demonstrated that a significant proportion of cases diagnosed as neurasthenia can also be classified under depression or anxiety: there are, however, cases in which the clinical syndrome does not match the description of any other category but does meet all the criteria specified for a syndrome of neurasthenia. It is hoped that further research on neurasthenia will be stimulated by its inclusion as a separate category.\(^{545}\)

Ultimately, neurasthenia was given a lengthy description that was later to raise a number of questions in comparison to other categories, and it can be viewed in Table 7.

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\(^{543}\) Kleinman, *Social Origins of Distress and Disease: Depression, Neurasthenia, and Pain in Modern China*, 194.

\(^{544}\) S. Lee, “Neurasthenia and Chinese Psychiatry in the 1990s,” *Journal of Psychosomatic Research* 38, no. 6 (August 1994): 487. Lee cites Kleinman’s *Social Origins* as the representative example of the “simply a somatized form of anxiety or depression” position.

Table 7: ICD-10 clinical description of neurasthenia

<table>
<thead>
<tr>
<th>F48.0 Neurasthenia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Considerable cultural variations occur in the presentation of this disorder; two main types occur, with substantial overlap. In one type, the main feature is a complaint of increased fatigue after mental effort, often associated with some decrease in occupational performance or coping efficiency in daily tasks. The mental fatigability is typically described as an unpleasant intrusion of distracting associations or recollections, difficulty in concentrating, and generally inefficient thinking. In the other type, the emphasis is on feelings of bodily or physical weakness and exhaustion after only minimal effort, accompanied by a feeling of muscular aches and pains and inability to relax. In both types, a variety of other unpleasant physical feelings, such as dizziness, tension headaches, and a sense of general instability, is common. Worry about decreasing mental and bodily well-being, irritability, anhedonia, and varying minor degrees of both depression and anxiety are all common. Sleep is often disturbed in its initial and middle phases but hypersomnia may also be prominent.</td>
</tr>
</tbody>
</table>

**Diagnostic guidelines**

Definite diagnosis requires the following:

(a) either persistent and distressing complaints of increased fatigue after mental effort, or persistent and distressing complaints of bodily weakness and exhaustion after minimal effort;

(b) at least two of the following:

- feelings of muscular aches and pains
- dizziness
- tension headaches
- sleep disturbance
- inability to relax
- irritability
- dyspepsia;

(c) any autonomic or depressive symptoms present are not sufficiently persistent and severe to fulfill the criteria for any of the more specific disorders in this classification.

**Includes:** fatigue syndrome

**Differential diagnosis.** In many countries neurasthenia is not generally used as a diagnostic category. Many of the cases so diagnosed in the past would meet the current criteria for depressive disorder or anxiety disorder. There are, however, cases that fit the description of neurasthenia better than that of any other neurotic syndrome, and such cases seem to be more frequent in some cultures than in others. If the diagnostic category of neurasthenia is used, an attempt should be made first to rule out a depressive illness or an anxiety disorder. Hallmarks of the syndrome are the patient's emphasis on fatigability and weakness and concern about lowered mental and physical efficiency (in contrast to the somatoform disorders, where bodily complaints and preoccupation with physical disease dominate the picture). If the neurasthenic syndrome develops in the aftermath of a physical illness (particularly influenza, viral hepatitis, or infectious mononucleosis), the diagnosis of the latter should also be recorded.

**Excludes:** asthenia NOS (R53)

burn-out (Z73.0)

malaise and fatigue (R53)

postviral fatigue syndrome (G93.3)

psychasthenia (F48.8)
At about the same time, the taskforce working on the new edition of the DSM had to decide whether to reintroduce neurasthenia back into the American manual, and its members took a very different direction than the ICD. The DSM-IV Options book was published in 1991 as a “work in progress”, a look at the thought processes going into the new revision. Regarding the diagnosis we can read the following:

This category has a long historical tradition and is included in DSM-II, ICD-9, and ICD-10. Neurasthenia was not included in DSM-III for two reasons: 1) it was difficult to define in a way that would not excessively overlap with the Somatoform, Anxiety, and Depressive Disorders, and with nonpsychiatric medial conditions; and 2) the DSM-II diagnosis was rarely used. Nonetheless, Neurasthenia is frequently diagnosed in many other cultures and may be a frequent presentation in primary care settings (e.g., chronic fatigue syndrome).\footnote{American Psychiatric Association, DSM-IV Options Book: Work in Progress (7/1/91). (American Psychiatric Association, 1991.) See section I:11}

The taskforce ultimately concluded that it was “unlikely that this disorder will be included as a separate category in the official classification. Instead, Neurasthenia may appear as a subtype of Undifferentiated Somatoform Disorder”.\footnote{Ibid.} As I have already mentioned, the category ultimately was not included in DSM-IV (except as a translated form of “culture bound disorder”), but the reference to its frequent presentation in primary care as chronic fatigue syndrome echoed the nosological concerns of Derson Young mentioned above, with the difference between Young and the DSM taskforce being the nosological priority assigned to categories. Logically for Young, SJSR was the antecedent category, and new changes in the Western nosology were an introduction of chronic fatigue as a mere terminological effort that was not only dismissive of psychiatric practice around the globe but also prioritized the phenomenological picture of patients in the Western context.

These issues raised by the DSM-Options book as well as changes to the DSM framework appear to have prompted a number of researchers to ask whether neurasthenia and chronic fatigue were really different names for the same clinical phenomena. One British researcher put the issue this way, “The thesis of this essay is that the origins of ‘ME’ [myalgic encephalitis] lie not in 1955 or 1934, but in the last century, and in the condition known as neurasthenia”\footnote{S. Wessely, “Old Wine in New Bottles: Neurasthenia and ‘ME,’” Psychological Medicine 20, no. 1 (January 1990): 35–53, https://doi.org/10.1017/S0033291700013210.} The literature on
ME in Britain, or chronic fatigue syndrome in the US, is too vast to expend the space on here, but in the 1990s there was some consideration that these and neurasthenia were all a single entity. Similar claims stated that “chronic fatigue syndrome will meet the same fate as neurasthenia—a decline in social value as it is demonstrated that the majority of its sufferers are experiencing primary psychiatric disorders or psychophysiological reactions and that the disorder is often a culturally sanctioned form of illness behavior”. In 1992 Ware and Kleinman also engaged in a comparison between the categories, while still using the old qualitative data from a decade before. The question, specifically for the Chinese context, was beginning to cohere around the four categories of SJSR, neurasthenia, undifferentiated somatoform disorder (UDS), and chronic fatigue syndrome (CFS).

In 1988 the United States Centers for Disease Control and Prevention (CDC) published specific criteria regarding symptoms of increased fatigability in relation to what had previously been labeled “chronic Epstein-Barr virus syndrome”. Due to the fact that it was not certain whether Epstein-Barr virus would prove to be the causal agent, what came to be known as the Holmes criteria proposed that a set of particular symptoms should classically define chronic fatigue syndrome. At the time, most focus was placed on the idea that the chronic fatigue making up the syndrome was a result of latent viral infections, and CFS criteria were oriented towards this view. As a result, patient symptoms and physical findings were put forward as defining features of the syndrome, which are listed in Table 8.

549 I think it is safe to say that academic psychiatrists are in agreement that CFS and ME are considered to be the exact same entity, but different names are used due to the emphasis in Europe that a post-viral syndrome has been considered to underlie the disorder. This has also been an issue in the USA, where there is a significant literature on Epstein-Barr virus.


**Table 8: Holmes criteria for CFS (1998)**

<table>
<thead>
<tr>
<th>MAJOR CRITERIA:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. New onset of persistent or relapsing, debilitating fatigue or easy fatigability in a person who has no previous history of similar symptoms, that does not resolve with bed rest, and that is severe enough to reduce or impair average daily activity below 50% of the patient's premorbid activity level for a period of at least 6 months.</td>
<td></td>
</tr>
<tr>
<td>2. Other clinical conditions that may produce similar symptoms must be excluded by thorough evaluation, based on history, physical examination, and appropriate laboratory findings.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MINOR CRITERIA:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a symptom must have begun at or after the time of onset of increased fatigability, and must have persisted or recurred over a period of at least 6 months (individual symptoms may or may not have occurred simultaneously).</td>
<td></td>
</tr>
<tr>
<td>1. Mild fever—oral temperature between 37.5° C and 38.6° C, if measured by the patient—or chills. (Note: oral temperatures of greater than 38.6° C are less compatible with chronic fatigue syndrome and should prompt studies for other causes of illness.)</td>
<td></td>
</tr>
<tr>
<td>2. Sore throat.</td>
<td></td>
</tr>
<tr>
<td>3. Painful lymph nodes in the anterior or posterior cervical or axillary distribution.</td>
<td></td>
</tr>
<tr>
<td>4. Unexplained generalized muscle weakness.</td>
<td></td>
</tr>
<tr>
<td>5. Muscle discomfort or myalgia.</td>
<td></td>
</tr>
<tr>
<td>6. Prolonged (24 hours or greater) generalized fatigue after levels of exercise that would have been easily tolerated in the patient's premorbid state.</td>
<td></td>
</tr>
<tr>
<td>7. Generalized headaches (of a type, severity, or pattern that is different from headaches the patient may have had in the premorbid state).</td>
<td></td>
</tr>
<tr>
<td>8. Migratory arthralgia without joint swelling or redness.</td>
<td></td>
</tr>
<tr>
<td>9. Neuropsychologic complaints (one or more of the following: photophobia, transient visual scotomata, forgetfulness, excessive irritability, confusion, difficulty thinking, inability to concentrate, depression).</td>
<td></td>
</tr>
<tr>
<td>10. Sleep disturbance (hypersomnia or insomnia).</td>
<td></td>
</tr>
<tr>
<td>11. Description of the main symptom complex as initially developing over a few hours to a few days (this is not a true symptom but may be considered as equivalent to the above symptoms in meeting the requirements of the case definition).</td>
<td></td>
</tr>
</tbody>
</table>

**Physical Criteria:** Physical criteria must be documented by a physician on at least two occasions, at least 1 month apart.

| 1. Low-grade fever—oral temperature between 37.6° C and 38.6° C, or rectal temperature between 37.8° C and 38.8° C. |  |
| 2. Nonexudative pharyngitis. |  |
| 3. Palpable or tender anterior or posterior cervical or axillary lymph nodes. |  |

To make matters more complicated, CDC definitions for CFS were refined in 1994; these modified requirements have become known as the “Fukuda” criteria and can be found in Table 9.

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553 Ibid., 388–89.
Additionally, a case of “idiopathic chronic fatigue” was defined as “clinically evaluated, unexplained chronic fatigue that fails to meet criteria for the chronic fatigue syndrome”.\footnote{Keiji Fukuda, “The Chronic Fatigue Syndrome: A Comprehensive Approach to Its Definition and Study,” \textit{Annals of Internal Medicine} 121, no. 12 (December 15, 1994): 953, https://doi.org/10.7326/0003-4819-121-12-199412150-00009.}

\begin{table}
\centering
\begin{tabular}{|p{1\textwidth}|}
\hline
\textbf{A case of the chronic fatigue syndrome is defined by the presence of the following:}
\textbf{1)} clinically evaluated, unexplained, persistent or relapsing chronic fatigue that is of new or definite onset (has not been lifelong); is not the result of ongoing exertion; is not substantially alleviated by rest; and results in substantial reduction in previous levels of occupational, educational, social, or personal activities.
\textbf{2)} the concurrent occurrence of 4 or more of the following symptoms, all of which must have persisted or recurred during 6 or more consecutive months of illness and must not have predated the fatigue:
\begin{itemize}
\item[a)] self-reported impairment in short-term memory or concentration severe enough to cause substantial reduction in previous levels of occupational, educational, social, or personal activities
\item[b)] sore throat
\item[c)] tender cervical or axillary lymph nodes
\item[d)] muscle pain
\item[e)] multi-joint pain without joint swelling or redness
\item[f)] headaches of a new type, pattern, or severity
\item[g)] unrefreshing sleep
\item[h)] post-exertional malaise lasting more than 24 hours.
\end{itemize}
\hline
\textbf{A case of idiopathic chronic fatigue} is defined as clinically evaluated, unexplained chronic fatigue that fails to meet criteria for the chronic fatigue syndrome.
\hline
\end{tabular}
\end{table}

As already mentioned, there was some Chinese skepticism about the American codification of the category of CFS, as the American Psychiatric Association had removed neurasthenia from its manual at the same time that American psychiatrists like Kleinman had raised questions about the validity of SJSR. Introduction of a similar and nebulous category like CFS seemed hypocritical. Given all the classificatory changes that took place, researchers of psychiatric nosology were in an even more complicated conundrum than in 1980.

Within China there was still considerable debate regarding the history and validity of SJSR as a diagnostic category. For example, we can find instances of Chinese psychiatrists undertaking “Research on the Re-diagnosis of Shenjing Shuairuo” in attempts to determine how CCMD-\footnote{Ibid., 956.}
diagnosed SJSR patients would be labeled if assessed strictly using DSM-III criteria and symptom assessment batteries. One of the first of several such studies occurred around the beginning of 1990. Two research psychiatrists, from Tongji Medical University and Harbin Medical University respectively, diagnosed fifty-two patients with SJSR, excluding any known physiological pathology, at the end of 1989. These patients were each reassessed using DSM-III-R, ICD-10, the Hamilton anxiety scale, and the Hamilton depression scale. Chronic fatigue syndrome was not considered in this study, though such comparisons were to come. The diagnostic groupings can be seen in Table 10 below. One might immediately recognize that the differences between the systems are unsatisfying, and subsequent studies improved upon this problem. For our purposes, it is worth mentioning that the authors concluded that they were in agreement with many psychiatrists in their own country who believed that “Shenjing Shuairuo should be retained as a diagnostic label”. Additionally, it should be noted that, as ICD-10 allows for neurasthenia as a label, re-diagnosis of the fifty-two patients resulted in half the patients continuing to carry this diagnosis. The other half was dispersed among the various other labels. With the DSM, however, no patients could be diagnosed with neurasthenia, and most ended up being labeled with depression, generalized anxiety disorder (GAD), or adjustment disorder.

Writing in 1993, Li Lingjiang and Yang Desen (Derson Young) also continued to write about whether “SJSR should continue to be maintained as a psychiatric category”. Their conclusion was also that it should continue, though they voiced recognition that its conceptualization in Taiwan, Japan, and Hong Kong had diverged from the understanding held by Chinese psychiatrists. It seemed necessary to undertake empirical research in China to compare the diagnostic differences between SJSR, ICD-10 neurasthenia, and chronic fatigue syndrome (CFS), as this was where much of the Western literature had been focusing since 1988.

557 I should mention that this paper, as well as the next papers discussed below, assessed patients using the Hamilton Depression and Hamilton Anxiety inventories. These are common batteries used to determine whether there are enough symptoms present to qualify for a psychiatric diagnosis pertaining to anxiety or depression; additionally, the SCL-90 assesses seven other domains of symptoms. For a summary of these batteries, see Chapter 5 in: Sadock, Kaplan & Sadock’s Synopsis of Psychiatry.
558 赵 et al., “神经衰弱的再诊断研究,” 311: “同时本组资料支持国内多数学者意见，在我国应保留神经衰弱这一疾病名称...”.
560 Their descriptions rely in part on the special edition of Culture Medicine Psychiatry mentioned in the previous chapter, and their conclusions are very much the same.
### Table 10: Re-diagnosis of 52 SJSR patients from Zhao (Zhao) et al., 1991

<table>
<thead>
<tr>
<th>Diagnostic Label</th>
<th>CCMD-II</th>
<th>DSM-III-R</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurasthenia</td>
<td>SJSR/神经衰弱 52</td>
<td>Not included in DSM</td>
<td>27</td>
</tr>
<tr>
<td>Somatization disorder</td>
<td></td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>多数性躯体化障碍</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MDD</td>
<td></td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>重性抑郁正</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Moderate</td>
<td></td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>• Severe</td>
<td></td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Mixed anxiety and depressive disorder</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>混合性焦虑与抑郁障碍</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dysthymia</td>
<td></td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>抑郁性神经症</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GAD</td>
<td></td>
<td>13</td>
<td>3</td>
</tr>
<tr>
<td>广泛性焦虑</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adj-D</td>
<td></td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>适应障碍</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conversion disorder</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>癔症性躯体化障碍</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bipolar depression</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>双相情感障碍</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Panic attacks</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>恐怖发作</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OCD</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>强迫性神经症</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unspecified neurotic, stress-related, and somatoform disorders</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>未特定的神经症性与躯体形式障碍</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MDD= major depressive disorder, GAD= generalized anxiety disorder, Adj-D=adjustment disorder, OCD= obsessive compulsive disorder

In 1994 Li and others\(^{561}\) at Hunan Medical University Subsidiary Hospital undertook “Comparative Research on Shenjing Shuairuo and Chronic Fatigue Syndrome” in an effort to

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\(^{561}\)李凌江, 张亚林, 杨德森, and 郝伟. The final author differs from the next paper. See the References section below for those authors. Derson Young (杨德森) is an author on all these papers and has continued to be active in the debate since his disagreement with Kleinman in 1980.
understand the diagnostic consequences of the newest classificatory systems when applied to a cohort of Chinese patients whose primary complaint was the experience of easy fatigability that had first begun at least three months prior. The basic conceptual aim of the study was to determine how many in the cohort who could meet criteria for SJSR would also be diagnosable with either ICD-10 neurasthenia and/or Centers for Disease Control-chronic fatigue syndrome (CDC-CFS). The results were very interesting, but not without problems, as can be seen in Table 11 below. One of the immediate implications of their findings was that, although all 50 patients included in the study met criteria for SJSR, 18/50 did not meet criteria for either ICD-10 neurasthenia or CDC-CFS. Additionally, although 32/50 met criteria for ICD-10 neurasthenia, only 8 of those met criteria for CFS. The conclusions that can be drawn from this exercise are limited, but not meaningless.

Table 11: Comparison of Chinese patients’ diagnoses by classification system in Li, Zhang, Yang, and Hao (1994).

<table>
<thead>
<tr>
<th>Number</th>
<th>Diagnostic classification System</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total= 50</strong></td>
<td>CCMD-II</td>
</tr>
<tr>
<td>18</td>
<td>SJSR</td>
</tr>
<tr>
<td>24</td>
<td>SJSR</td>
</tr>
<tr>
<td>08</td>
<td>SJSR</td>
</tr>
</tbody>
</table>

First, while it may be tempting to argue that CCMD-II SJSR is distinct from ICD-10 neurasthenia in this population, it must be kept in mind that CCMD-II required only three months of symptoms while ICD-10 required six months (as does the CFS criteria). Since the inclusion criteria for the study only required three months, the study was likely to include patients who would meet CCMD-II but not ICD-10 diagnostic criteria. In fact, the authors attribute the isolated eighteen SJSR diagnoses to this fact.

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563 Part of the inclusion criteria was that patients underwent work-up to rule-out any organic basis for their complaints. They all therefore had symptoms of fatigue with no determinable, physiological cause.

564 I should also mention that, in addition to the Hamilton Scales, this paper also used the Symptom Checklist-90 (SCL-90), which assesses nine domains of symptoms. The groups were not significantly different when compared across their various symptom battery scores. For a summary of these batteries, see Chapter 5 in: Benjamin J. Sadock, *Kaplan & Sadock's Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry*, 11th ed. (Wolters Kluwer, 2015).
Second, most of the patients who met both CCMD-II and ICD-10 criteria did not meet CFS criteria, despite the fact that they met the time duration requirements. This finding implies that there are other aspects of the CFS operationalization that distinguish the category from neurasthenia. In the present case, only eight patients met the criteria for fevers, sore throat, joint pain, etc., that were required by CDC. In sum, forty-two of the fifty SJSR patients could not be labeled with CFS, prompting the authors to point out that “among those who can be diagnosed with SJSR, most cannot be diagnosed with CFS, but it is not the case that those who are diagnosed with CFS cannot be diagnosed with SJSR”\textsuperscript{565}. That is to say, using diagnostic criteria, it could have been stated that all CFS were also SJSR, but not all SJSR were CFS. For the Western reader, it should also be recognized that all CFS was also diagnosable as neurasthenia (ICD-10), but not all neurasthenia was diagnosable as CFS. They conclude that perhaps CFS should be recognized as a form or sub-category of neurasthenia in ICD-10\textsuperscript{566}. Indeed, “fatigue syndrome” is listed in ICD-10 as something that is included within the diagnostic rubric of neurasthenia\textsuperscript{567}.

In a similar study conducted from 1992 to 1994, Li and Yang attempted to bring clarity to the issue of comparative diagnosis and possible equivalencies between categories within the various diagnostic systems discussed above\textsuperscript{568}. Once again at Hunan Medical University Subsidiary Hospital, patients were included whose chief complaint was easy fatigability with onset at least three months prior. After ruling out organic disease, ninety-six patients were included in the study and assessed for any diagnosable condition using CCMD-II-R, ICD-10, DSM-III-R, and CDC criteria for CFS. Unlike their previous study, the DSM is included here, which makes possible the diagnosis of unspecified somatoform disorder in addition to any other diagnosis available in the system. The results of cross-diagnosis can be seen in Table 12 below.

\begin{table}
\centering
\caption{Results of Cross-Diagnosis}
\end{table}

\begin{thebibliography}{99}
\item \textsuperscript{565} Ibid., 162: “因而本研究 中出现 了可诊断 为 神 经 衰 弱 而 大多 不 能 诊断 为 慢 性疲 劳 综 合 征, 但 却 没 出现 可 诊断 为 慢 性疲 劳 综 合 征 而 不能 诊断 为神 经衰 弱 的 情 况”.
\item \textsuperscript{566} That is not to say that SJSR is a form of CFS. Rather, CFS is just one presentation of SJSR.
\item \textsuperscript{567} See Table 7 above: “Includes: Fatigue syndrome”.
\item \textsuperscript{568} 李凌江 et al., “非器质性慢性疲劳综合征的诊断归属” [A diagnostic study of patients with medically unexplained chronic fatigue], 临床精神医学杂志 [Journal of clinical and psychological medicine] 6 (1996): 325–28. The authors include 李凌江, 杨德森, 张亚林, and 郑延平
\end{thebibliography}
Table 12: Comparison of Chinese patients’ diagnoses by classification system in Li, Yang, Zhang, and Zheng (1994).

<table>
<thead>
<tr>
<th>Group</th>
<th>Total = 96</th>
<th>CCMD-II-R</th>
<th>ICD-10</th>
<th>DSM-III-R</th>
<th>CDC-CFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>16 patients</td>
<td>Depressive neurosis</td>
<td>Dysthymia</td>
<td>Dysthymia</td>
<td>CFS (2)</td>
</tr>
<tr>
<td>B</td>
<td>10 patients</td>
<td>GAD</td>
<td>GAD</td>
<td>GAD</td>
<td>CFS (1)</td>
</tr>
<tr>
<td>C</td>
<td>08 patients</td>
<td>SJSR</td>
<td>USD</td>
<td>No diagnosis</td>
<td>0 patients</td>
</tr>
<tr>
<td>D</td>
<td>49 patients</td>
<td>SSJSR</td>
<td>Neurasthenia</td>
<td>USD</td>
<td>0 patients</td>
</tr>
<tr>
<td>E</td>
<td>13 patients</td>
<td>SJSR</td>
<td>Neurasthenia</td>
<td>USD (9), No diagnosis (4)</td>
<td>CFS (3)</td>
</tr>
</tbody>
</table>

GAD= generalized anxiety disorder, USD= undifferentiated somatoform disorder, CFS=chronic fatigue syndrome, SJSR= Shenjing Shuairuo

Groups A and B represent patients with psychiatric disorders that also met criteria for CFS, and the authors were not particularly interested in these groups as they had a primary psychiatric diagnosis. As with the previous study, the symptom duration used for inclusion necessitates that some patients diagnosable with SJSR by CCMD (only three months needed) will not meet criteria for ICD neurasthenia (six months needed). This most likely accounts for patient differences between CCMD and ICD in group C as USD is not constrained by duration of symptoms. The authors’ interests are specifically in the fact that, out of ninety-six patients, seventy were diagnosable with CCMD-SJSR, and sixty-two met criteria for ICD neurasthenia. This, they argue, “suggests that Shenjing Shuairuo constitutes one type of psychiatric disorder that indeed exists within clinical practice, and retention of the neurasthenia label in Chinese and international classification systems is appropriate to clinical practice”.

However, the more interesting aspect of their findings pertains to the application of the DSM to those patients diagnosable with CCMD-SJSR or ICD neurasthenia in groups C, D, and E. In those groups where 70 of the 96 patients could be labeled CCMD-SJSR, 59 received a DSM diagnosis of USD and 12 received no DSM diagnosis at all. In other words, nearly all 70 SJSR patients were labeled as USD by the DSM standards. The

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569 李凌江 et al., 327, “提示神经衰弱作为精神障碍的一个类型，确实存在于临床上，我国与国际精神疾病分类中保留神经衰弱的诊断名称是符合临床实际的”.

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researchers therefore ask the question, “does this suggest that neurasthenia in Europe and America has disappeared, or rather that in the DSM the majority of such cases have been attached to another diagnostic labels, namely Undifferentiated Somatoform Disorder”. Though it is not stressed in the conclusion of their study, one might also point out that a number of SJSR patients (12/70) received no diagnosis at all by DSM standards. Additionally, the same conclusions regarding CFS hold as in the previous study. Overall, what the researchers appear sufficiently to have demonstrated is the fact that SJSR serves as a category in the Chinese system that describes a set of experiences for which patients seek-out professional help, which experiences may not adequately be captured or accounted for by the DSM classificatory system.

While Chinese psychiatrists were engaged in these kinds of research projects in the early 90s in China, researchers in the USA were also thinking about some of the same issues. Given that there is a paucity of English language materials describing the findings or work of academics in China, the subject could have remained constrained by language barriers if there were not some native Chinese speakers to take up the issue. Publishing predominantly in English, these issues were thankfully taken up in earnest by psychiatrist and University of Hong Kong professor Sing Lee during the mid-1990s, a period which overlapped with his appointment as a Fellow in Harvard’s department of Social Medicine. The question that he wanted to address directly was whether the ICD definition of neurasthenia was compatible with the experience and presentation of Chinese patients; if so, then one might further pursue the idea that neurasthenia, UDS, and CFS were getting at the same phenomena outside of China that SJSR was getting at inside China.

Review of Table 7 above should demonstrate that ICD characterizes neurasthenia with hierarchical criteria, with the predominant feature being fatigue or weakness that is either mental or physical in nature. CCMD, on the other hand, has never required that fatigue be a necessary symptom for a diagnosis of SJSR. In ICD, fatigue is given as the main complaint; accompanying this primary symptom are others such as headache, dizziness, and sleep disturbance. Lee was aware that this operationalization of neurasthenia did not match past experience or some contemporaneous studies of SJSR. For instance, Kleinman had made the same assumptions in 1984 about SJSR that ICD codified with regard to neurasthenia in the early 1990s. Weakness and

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570 Ibid., 327–28: “提示神经衰弱在欧美国家可能并未消失，而是在 DSM 系统中大多数被贴上另一种疾病诊断的标签，即未分化的躯体形式障碍?”
loss of energy may have been common descriptions of neurasthenia in Beard’s day, but Kleinman found that only thirty to thirty-five percent of his Chinese study subjects carried such complaints. In 1984 he wrote, “This surprised us since weakness and exhaustion are central problems in traditional Chinese medicine where they are related to lack of qi and imbalance between yin/yang. For this reason, we assumed they would be a ready-made traditional Chinese cultural form for integration into the diagnosis of neurasthenia. It remains unclear why they are present in only a minority of cases”.571 Fatigue, in fact, had not made it into Kleinman’s list of complaints, while headache, insomnia, and dizziness made up seventy-three to ninety percent of patient concerns. His surprise at this fact illustrates his preconceptions that prevented him from fully considering SJSR’s long historical background in China and the cataloguing of its symptoms within popular and professional culture, which long predated Kleinman’s first visit to Asia. Nevertheless, this discrepancy with the more recent ICD framing of neurasthenia led to a reexamination of its symptom profile and comparison across diagnostic systems.

Lee’s research set out to determine the extent to which fatigue, as opposed to other bodily complaints, constituted SJSR in its symptom profile. One can image that prior committees working on ICD, who were likely aware of the Western history of neurasthenia, simply assumed that the clinical category in China that translates as “neurasthenia” into English would have the same symptoms and constitute the same syndrome as the known phenomenon of “neurasthenia” in the West. However, translation need not imply equivalence, and Lee published a significant number of papers that cast doubt on the idea of the CCMD-ICD equivalence between the categories of SJSR and neurasthenia as they are operationalized. While it is not necessary systematically to review all of Lee’s publications from the 1990s, for the sake of thoroughness I should address his overall project from that period as it pertains to our subject matter.

Continuing my chronological approach to these matters, I refer readers to Lee’s 1994 editorial “Neurasthenia and Chinese Psychiatry in the 1990s”, which he published in the Journal of Psychosomatic Research.572 This paper is an important contribution to our topic as Lee makes explicit the distinction between the CCMD and the ICD insofar as the ICD requires fatigue as first among a hierarchy of symptoms necessary for the diagnosis of neurasthenia, whereas the CCMD requires three out of five symptoms that may or may not include fatigue. Making reference to some

572 Lee, “Neurasthenia and Chinese Psychiatry in the 1990s.”
of his own studies in Hong Kong, he points out that the most common symptoms attributed to the illness concept of SJSR are insomnia, anxiety, depression, and fright; fatigue is not among them.\textsuperscript{573} The illness concept common among lay persons is not the same, however, as the actual symptom endorsement of patients. Nevertheless, Lee suggested that there may be some aspect of the Chinese experience of SJSR that does not quite fit the ICD formulation of a syndrome of fatigue. While SJSR continues to serve Chinese populations, the various “somatoform” categories of the DSM and the ICD such as \textit{quti hua tengtong zhang ai} (躯体化疼痛障碍, somatoform pain disorder), \textit{wei fenhua quti zhangai} (未分化躯体障碍, undifferentiated somatoform disorder), and others, are as “as weird as they are experience-distancing”.\textsuperscript{574} He concludes that we should, “Let the sufferers speak more”.\textsuperscript{575}

In the same year, Lee continued with “The Vicissitudes of Neurasthenia in Chinese Societies: Where Will It Go from ICD-10?”, where he further argued that the ICD descriptions of neurasthenia may not be true to the illness experiences of Chinese patients carrying SJSR diagnosis.\textsuperscript{576} Recall from earlier in this chapter that the \textit{ICD-10 Classification of Mental and Behavioural Disorders} publication of clinical descriptions made the following statement about neurasthenia: “Although omitted from some classification systems, neurasthenia has been retained as a category in ICD-10, since this diagnosis is still regularly and widely used in a number of countries”.\textsuperscript{577} Lee suggests that on this basis, the formulation of neurasthenia in the ICD might be conceived of as constituting a “category fallacy”\textsuperscript{578} since the formulation does not match that of the country wherein the category is most widely used. For example, Table 13 lists the diagnostic criteria for CCMD-2 and ICD-10 in parallel. It can be seen that the hierarchical nature of the criteria for the ICD is such that cases of SJSR may fail to meet ICD criteria. Once again he concluded, “Let the sufferers speak for themselves”.\textsuperscript{579}

\textsuperscript{573} Ibid., 489.
\textsuperscript{574} Ibid., 490. The Chinese terms here are clinical and unlikely ever to be endorsed by patients.
\textsuperscript{575} Ibid.
\textsuperscript{577} World Health Organization, \textit{The ICD-10 Classification of Mental and Behavioural Disorders}, 19.
\textsuperscript{578} See Chapter Four for a discussion of “Category fallacy”.
Table 13: Comparison of CCMD-2 and ICD-10 criteria for a diagnosis of neurasthenia

<table>
<thead>
<tr>
<th>CCMD-2</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Must have 3/5 symptoms, lasting three months and causing:</td>
<td>Definite diagnosis requires the following lasting for six months:</td>
</tr>
<tr>
<td>(i) lower work or study efficiency, or disruption of social functioning,</td>
<td>(a) either persistent and distressing complaints of increased fatigue after mental effort, or persistent and distressing complaints of bodily weakness and exhaustion after minimal effort;</td>
</tr>
<tr>
<td>(ii) mental distress, or</td>
<td></td>
</tr>
<tr>
<td>(iii) cause person to seek treatment.</td>
<td></td>
</tr>
<tr>
<td><strong>List of symptom groups:</strong></td>
<td>(b) at least two of the following:</td>
</tr>
<tr>
<td>(a) Weakness: mental or physical. Mental includes poor memory or difficulty in concentration.</td>
<td>- feelings of muscular aches and pains</td>
</tr>
<tr>
<td>(b) Affective symptoms, dysphoria</td>
<td>- dizziness</td>
</tr>
<tr>
<td>(c) Excitement: easy excitability, sensitivity to sound or light</td>
<td>- tension headaches</td>
</tr>
<tr>
<td>(d) Aches pains: such as headaches or myalgias</td>
<td>- sleep disturbance</td>
</tr>
<tr>
<td>(e) Sleep disturbances</td>
<td>- inability to relax</td>
</tr>
<tr>
<td></td>
<td>- irritability</td>
</tr>
<tr>
<td></td>
<td>- dyspepsia</td>
</tr>
<tr>
<td><strong>Exclusion:</strong></td>
<td></td>
</tr>
<tr>
<td>Other physical and psychiatric disorders causing these symptoms exclude diagnosis of SJSR.</td>
<td>Exclusion: Any autonomic or depressive symptoms present must not be sufficiently persistent and severe to fulfill the criteria for any of the more specific disorders in this classification.</td>
</tr>
<tr>
<td><strong>Fatigue not a mandatory symptom group</strong></td>
<td>Fatigue/weakness is a mandatory symptom</td>
</tr>
</tbody>
</table>

Writing two years later, Lee again took up the issue of “cultures in psychiatric nosology” in a lengthy review and comparison of all the major psychiatric categories in ICD-10 and CCMD-2-R.\textsuperscript{580} He had already demonstrated that among college students in Hong Kong, the illness concept of SJSR differed from the ICD formulation,\textsuperscript{581} and his earlier analyses suggested the same about patient experiences. When he arrived at the subject of neurasthenia in his 1996 review he wrote that “the ICD-10 definition of neurasthenia, which requires fatigue (or weakness) as a mandatory core symptom, misrepresents the illness reality of Chinese neurasthenic patients. In Hong Kong, insomnia and headache are usually the ‘core’ symptoms. So, the CCMD-2-R

configuration of neurasthenia, in which any three out of five non-hierarchical groups of weakness, dysphoria, excitement, nervous pain, and sleep symptoms constitute the diagnosis, is more congruous with the Sinicized version of neurasthenia. It also eliminates the nosological need for somatoform disorders”. While he may be technically correct, it should be mentioned that CCMD-2-R seems to have attempted to follow the ICD by framing SJSR as a disorder whose “primary clinical picture is one of easy excitability associated with ease of mental fatigability”. Furthermore, the listed criteria contain the necessary requirement that “a weakening of brain-function constitutes the primary clinical picture”, with three out of five symptom types present. While the “fatigue symptoms” (衰弱症状) need not be one of the three necessary symptom clusters present, the second criteria is clear regarding the requirement of brain-function weakness (脑功能衰弱症状为主要临床相). Unfortunately, other authors make reference to Lee without realizing that the Chinese text very heavily leans toward mental fatigue or other cognitive symptoms. Writing in 1999, for example, Starcevic claims that SSJR diagnosis can be made using CCMD-2 “without the presence of fatigue, weakness, or exhaustion”. While the symptom cluster containing fatigue, weakness, or exhaustion need not be present in the patient experience, the disorder appears to be framed as one of cognitive fatigue, excitability, or decreasing mental performance. In any case, the matter is further cleared up in CCMD-3. In that edition, the first of five sets of symptom clusters from CCMD-2-R was moved up in the requirements of CCMD-3 such that the “weakness symptoms” (衰弱症状) were placed in the necessary criteria section.

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582 Lee, “Cultures in Psychiatric Nosology,” 439
583 Zhonghua yixuehui jingshen kexuehui, and Nanjing yike daxue naoke yiyuan, 中国精神疾病分类方案与诊断标准 (Dongnan daxue chubanshe, 1995), 85.
584 Ibid., 86
586 Recall that the ICD claims neurasthenia is of two main types: “In one type, the main feature is a complaint of increased fatigue after mental effort, often associated with some decrease in occupational performance or coping efficiency in daily tasks. The mental fatigability is typically described as an unpleasant intrusion of distracting associations or recollections, difficulty in concentrating, and generally inefficient thinking. In the other type, the emphasis is on feelings of bodily or physical weakness and exhaustion after only minimal effort, accompanied by a feeling of muscular aches and pains and inability to relax”. I am not sure that Lee has really made the case that SJSR is defined much differently from the first of these two, with criteria that also allow for the second. I am not sure if Starcevic can read Chinese, but if he was reading the CCMD he should see that the manual leans heavily toward, and in fact requires, 脑功能衰弱.
rather than being in a list of multiple, possible symptom types.\textsuperscript{587} In this manner, CCMD-3 mirrors ICD-10.

Still, it is true that CCMD-2-R basically did exclude the somatoform disorders that were codified in the DSM and ICD-10, a subject Lee wrote about in 1997.\textsuperscript{588} Those categories were later added to CCMD-3 as well, however. While his contention was that the translations of the categories were unidiomatic and experience-distancing, they further relied on the philosophical distinction between functional versus organic conceptions of disease. Additionally, it was unlikely that many of China’s non-urban peoples, or even many living in urban centers, would have the resources to meet the criteria, which required “repeated presentation of physical symptoms together with persistent requests for medical investigations, in spite of repeated negative findings and reassurances by doctors that the symptoms have no physical basis”\textsuperscript{589} Still, one could question whether cases of SJSR were equivalent to the DSM cases of “undifferentiated somatoform disorder”. As the decade of the 1990s was drawing to a close, however, Lee could remark that “SJSR owns and will continue to elaborate a cultural history too rich to be ignored”.\textsuperscript{590}

It is surprising, then, that Lee’s last major publication of the 90s was one that weighed-in and returned specifically to the “neurasthenia-depression controversy”, despite the unresolved nature of the somatoform, chronic fatigue, and ICD neurasthenia questions about cross-cultural equivalences. He begins with the supposition that “psychiatric disease categories are not isolable things-in-themselves, but products of vested interests, political strategies, and ambivalent social practices”.\textsuperscript{591} This social-constructionist approach to psychiatric classification allows for some serious questioning regarding the changes and controversies addressed both in the previous and current chapter. Lee takes his readers through several categories of influence that he believes have led academic psychiatrists in China to marginalize older views of SJSR and recast them as depressive disorder. He refers to “the opening of China and DSM hegemony” as a source of

\textsuperscript{587} 中华医学会精神科分会, 中国精神障碍分类与诊断标准, vol. 3 版 [CCMD-3] (山东科学技术出版社, 2001), 113.
\textsuperscript{589} ICD-10 Somatoform disorders, F-45.
scientism in a post-Mao, 1980s China, such that the authority and perceived superiority of Western psychiatry threw Chinese practice into question. With the influence of the American Psychiatric Association and the DSM, multinational pharmaceutical corporations made their way into the vast Chinese market. Lee describes how medical graduates receiving salaries several times higher than a practicing physician would be groomed to influence prescribing and diagnosing practices of Chinese physicians in the 1990s. New generation “antidepressants”, the selective serotonin re-uptake inhibitors (SSRIs), were developed in the early 1990s. Prozac had already been approved by the FDA in 1987, and its use in China under the translation Baiyou-jie (百憂解), or “the undoer of a multitude of woes” could be sold for anywhere from fourteen to twenty-seven times the cost of the older tricyclic-antidepressants, depending on whether the drug was respectively imported or manufactured domestically. He wrote, “For better or worse . . . pharmaceutical companies are ahead of the CCMD schema in expanding the perceived burden and concept of depression”. If the “neurasthenia-depression controversy” was leaning more heavily in one direction, it was certainly not for lack of interested parties. Though it was not his intention, Kleinman’s initial approach to SJISR in China and the controversy that it sparked turned out to be very useful in marketplaces besides the marketplace of ideas. Unfortunately, Lee is not able explicitly to make the connection between the early efforts of the NCCP and its usefulness for commercial gain.

Tracing the various influences of pharmaceutical corporations on the shaping of psychiatric nosology is not my aim in this project. Nevertheless, such forces appear to be at work presently as, for example, the DSM continues to broaden its scope of who can be diagnosed with depression; the once horrific and rare condition of melancholia as described by Robert Burton in 1621 is not the depression of today. The medicalization of everyday difficulties and experiences opens up the possibility of exposing many more people to the commercial markets of psychiatric drugs, and other writers have addressed those issues elsewhere. Suffice it to say that the 1990s served as a

592 Ibid., 363.
593 Ibid., 364.
594 Kirmayer’s experience with GlaxoSmithKline in their efforts to understand how cultural variation might be harnessed to increase antidepressant sales in Japan is a good example of the vested interests in nosology and labeling. See: Laurence J. Kirmayer, “Beyond the ‘New Cross-Cultural Psychiatry’: Cultural Biology, Discursive Psychology and the Ironies of Globalization,” Transcultural Psychiatry 43, no. 1 (March 1, 2006): 126–44, https://doi.org/10.1177/1363461506061761; Watters, Crazy like Us.
595 Edward Shorter, How Everyone Became Depressed (Oxford University Press, 2013), 256; Thomas Szasz, The Myth of Mental Illness: Foundations of a Theory of Personal Conduct (Harper & Row, 1961); Allan V. Horwitz and
further period of inquiry and contestation regarding the meaning of SJSR as an illness category that was not immune to such market concerns. The “neurasthenia-depression controversy” was to continue in various forms at the turn of the millennium.

5.3 SJSR at the Turn of the Millennium

Despite the fact that Chinese psychiatrists had made efforts at modifying their national classificatory system in such a way as to differentiate clearly between depression and neurasthenia, with the diagnosis of SJSR being excluded when there was evidence of a depressive disorder, even in 2001 there were Western writers who felt it necessary to review “evidence for the claim that lower rates of depression among Chinese reflect denial of the illness or tendency to express depression somatically”. The suspicion that “Chinese somatize” or otherwise do not experience “depression” as Westerners do has continued to be widely held, and it was among the theoretical explanations for the lower prevalence of depression in large epidemiological efforts in China. At the turn of the millennium, some of the same writers continued to lend support to such ideas.

Kleinman continued occasionally to make some of the same types of claims that he had made nearly twenty-five years prior. For instance, in 2004, he offered a perspective piece in The New England Journal of Medicine with the exotic-appearing Chinese characters for “depression” prominently enlarged in the middle of the page, as can be seen in Figure 19. The caption beneath the characters informs readers that “the Chinese characters for ‘depression’ are employed in medical settings but are not in popular usage”. Being a “perspective” piece, such claims can go without citing any evidence, and one is reminded of similar claims in the 1980s regarding Chinese speakers’ lack of terminology for depressive emotional states.

Jerome C. Wakefield, The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder (Oxford University Press, 2007); Watters, Crazy like Us.


598 I have often wondered why this claim has gone unchallenged. Perhaps Chinese readers feel that it is not worth the time or trouble publicly to contradict. In any case, I take these types of claims to be evidence of a lack of competent access to historical Chinese linguistic and literary sources. That is to say, the claim-maker does not know what he is talking about or is not interested in the facts of the matter.
What does he mean by the claim “not in popular usage”? For the sake of argument, let us assume that he no longer means that the Chinese language is “relatively impoverished in psychological terminology”. Does he then mean that it is not popularly understood what these characters mean? Does he mean that Chinese people with various types of emotional distress simply will not refer to these Chinese terms, and they are therefore not popular in usage? I find both of these ideas to

599 Kleinman, Patients and Healers in the Context of Culture, 135.
be completely unfounded. In 1980 he made reference to the term 悲 (men) as an undifferentiated term, presumably without awareness that the term had been used variously to describe emotional grief or sorrowfulness since the time of the Daodejing. When combined with 悲 (yu), 悲闷 (yumen) can be found describing sorrow and depression as early as the Romance of the Three Kingdoms sometime around the fourteenth century, and the term also appears in the Record of the Three Kingdoms substantially earlier. It is not surprising, then, that the most famous cultural production among literate Chinese for centuries also includes language very similar to the classical texts mentioned here. In Dream of the Red Chamber, we read of spats between Baoyu and his granny’s servant in Chapter 3. When he ignores her she feels melancholy (心中著實憂鬱). Later in Chapter 64, we learn of Baoyu’s concern about Lin Daiyu growing dangerously sorrowful. Baoyu uses the term 悲 (yu) when he refers to his competing concerns that his visit may either “vex her to the point of holding in all her emotions (煩惱鬱結於心), or help her give expression to her grief so that her “sorrow doesn’t lead to illness” (抑鬱致病). Suffice it to say, variants (憂鬱/embarrassed, 抑鬱/depresed) have been in use among literate Chinese for centuries, which is precisely how contemporary clinical terms come to palatable translations. The translation for “depression” as a diagnostic category is not made up out of thin air. As is clear even from this concise discussion here, the terms have been around to describe depressive-like symptoms for a long time.

One might then wonder whether the term 忧鬱症 appears in popular media in China, given that it is claimed not to be in popular usage. A cursory look at print news databases from the year before Kleinman’s perspective piece (2003) reveals that “忧鬱症” appeared as a subject of articles in 13 issues of the People’s Daily (人民日报), 12 issues of Beijing Daily (北京日报), 12 issues of

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600 For the Romance, see 三國演義, 第 011 回: “管亥分兵四面圍城, 孔融心中鬱悶。糜竺懷愁, 更不待言”。 The much earlier reference from the Records can be found here: 三國志, 卷二十九, 魏書·方技傳. “裴使君聞言, 則慷慨曰：「何乃爾邪！雖在大州, 未見異才可用顧人鬱悶者, 思還京師, 得共論道耳, 況草聞自有清妙之才乎? 如此便相為取之, 莫使騷驥更為凡馬, 荊山反成凡石」”.


602 曹雪芹. See Chapter 64 (第 064 回) where it is written: “但此此時走來, 見他傷感, 必极力勘懸, 又怕他煩惱鬱結於心, 若不去, 又恐他過于傷感, 無人勸止。兩件皆足致疾。莫若先到鳳姐姐處一看, 在彼稍坐即回。如若見林妹妹傷感, 再設法開解, 既不至使其過悲, 哀痛稍申, 亦不至抑鬱致病”.

603 Contrast this with “undifferentiated somatoform disorder”, which is made-up out of thin air and truly is “not in popular usage”. Hence, it is not a palatable translation.
Liberation Daily (解放日报), 12 issues of Southern Daily (南方日报), and 11 issues of Workers Daily (工人日报), and many other such daily newspapers and periodicals.\textsuperscript{604} This amounts to more than one article per month across many different publications. The idea that the Chinese term for depression is not in popular usage is rightly labeled a matter of perspective. It is an opinion that appears ill informed. To press the issue further still, an examination of print databases from years approaching the establishment of the People’s Republic is also telling. The term 忧郁 appears in over 190 non-medical publications from 1940 to 1949.\textsuperscript{605} The idea that the term is not present in the popular lexicon in 2004 is very dubious indeed.

Returning to the perspective piece, we find that the article opens with the following claim: “In many parts of Chinese society, the experience of depression is physical rather than psychological. Many depressed Chinese people do not report feeling sad, but rather express boredom, discomfort, feelings of inner pressure, and symptoms of pain, dizziness, and fatigue”.\textsuperscript{606} Such commentary not only helps perpetuate stereotypes in the literature by implying that many Chinese people are unique in this matter, but it also fails to inform the reader that many (perhaps most) people of all types who are labeled with depression do not report feeling sad, but express boredom, discomfort, feelings of pain, dizziness, and fatigue. At the time of the above mentioned publication in 2004, the DSM was in its fourth edition (DSM-IV-TR); its criteria for major depressive episode are listed in Figure 20 for convenience. The reader will notice that “depressed mood” is not a necessary requirement, and most symptoms are physical in nature, forcing the question as to why Kleinman feels it necessary to make such claims about Chinese people. It appears that, even in 2004, he continues to insist on the dichotomy between somatizing and psychologizing that he popularized decades before when he initially claimed that Westerners psychologize and Chinese people lack the linguistic capacity and cultural normativity to psychologize and therefore somatize as a result.

\textsuperscript{604} For those who wish to verify my claim here, please see the Chinese state-managed database at the following website: http://www.cnki.net/ A simple search there of the term “忧郁症” will yield 117 publications from 2003, which is the year I refer to here. In 2004 the number of publications was 105. Of course, the academic literature is much more prolific, but this is popular usage as can be found in newspapers. It does not even begin to address the numbers of such reference on television, on the internet, in fiction, or in other such realms of “popular usage”.

\textsuperscript{605} For those interested in old newspapers and gazetteers from 1900–1949, see http://www.cnbksy.cn/

\textsuperscript{606} Kleinman, “Culture and Depression.”
Criteria for Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

(1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.

(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).

(3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.

(4) insomnia or hypersomnia nearly every day

(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

(6) fatigue or loss of energy nearly every day

(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

Figure 20: DSM-IV criteria for depression

The conceptual dichotomy between somatization and psychologization received ever more rigorous investigation in the first decade of the twenty-first century, and it looks doubtful that earlier claims about a uniqueness of Asian somatizing held much merit. Not only has the concept of somatization since been addressed in a much more careful manner, as discussed in section two above, some research made clear that comparison of depression/neurasthenia symptom

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presentations in Chinese and North American patients is rather complicated and nuanced. Studying patients in 2002 from psychiatric clinics in Canada and at the same hospital site as Kleinman’s original work in China, Ryder et al. demonstrated that cultural differences in somatic symptoms were the greatest during structured interview with an unknown clinician, less still when symptoms were prompted using indirect and open questions allowing spontaneous patient narrative, and differences disappeared when patients respond privately to a symptom questionnaire. What appears more accurate about the old dichotomy is that, even though psychological presentations are not rare in China, at least in psychiatric clinics, patients labeled as depressed from North American seem to describe a psychological component of their experience more often, regardless of which of the three assessment methods are used.

Using the same sample data from 2002, Dere et al. were later able to argue that we move “[b]eyond ‘somatization’ and ‘psychologization’” due to some interesting findings from more sophisticated analysis of symptom reporting. When “somatic” symptoms and “psychological” symptoms are examined on the basis of individual symptoms themselves, rather than as respective sets of symptom types, there may very well be “forms of somatization that are more common in ‘Western’ contexts”. Furthermore, with respect to psychologization, it appears that cultural scripts regarding concepts like “hopelessness” may play a large part in Western cognizing about the depression experience. The researchers suspect that cultural scripts in China also changed immensely since the days of Kleinman’s early work there, but unfortunately, we are limited in our manner of studying such change as we do not have access to any (1980s) reliable, quantitative data of the type used to challenge the somatic/psychological dichotomy in 2002. For that reason, those

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608 One difficulty of studies like the one mentioned here is that researchers are forced to include symptom criteria from both DSM depression and CCMD neurasthenia in order to capture all the people and phenomena they hope to study. By calling it depression/neurasthenia, I am not accepting equivalence, as I am sure the reader is aware. In fact, I think this difficulty is the major weakness of such studies, as it forces the logical fallacy of “begging the question”, petitio principii, when it comes to the existence of depression, neurasthenia, or any other clinically labeled phenomena. That is to say, it begs the question regarding the somatization of the psychologization of what?


611 Ibid., 10.
clinging to the old claims regarding the dichotomy can simply claim that Chinese used to somatize more. Expectedly, just such claims were explicitly made in 2017, and they unsurprisingly relied on Kleinman’s past work, as will be seen in the first section of the concluding chapter below. Nevertheless, decades of repeating the same claims about Chinese somatization/deficient psychologization appear to have made it easy for an experienced professor of anthropology, Jie Yang, to make outrageous statements like the claim that Chinese used “exclusively” to present mental distress with somatic complaints.\footnote{Jie Yang, Mental Health in China: Change, Tradition and Therapeutic Governance (John Wiley & Sons, 2017), 34.} This once again raises the topic of changing cultural scripts. Should we believe that cultural scripts in China have changed such that Chinese people are now psychologizing more? That is a fundamental question underlying Kleinman’s perspective piece and Jie Yang’s comment above. Should one be surprised if, after Kleinman’s many publications, pharmaceutical marketing efforts, and over two decades of Western psychiatric influence of professional bodies like the American Psychiatric Association, Chinese people have new and altered ideas about “mental disorders” and how they should think and talk about life difficulties? Cultural, economic, and political influence is very much capable of introducing new ideas and facilitating their adoption. We must be cautious regarding what we claim such changes to evince.\footnote{“Depression”, as it is defined today, is almost embarrassingly broad in its scope. Furthermore, I am not sure that Chinese adoption of American-styled, self-absorbed psychologization is something to laud as a great societal achievement. Still, the real issue is how the rise in incidence and prevalence of “mental disorders” should make us question whether or not the change in statistics is caused by creation of phenomena that were not there before.}

Such theoretical claims aside, the first decade of the twenty-first century also had its own fair share of research literature investigating equivalencies between SJSR and other diagnostic categories, as was seen throughout the 1990s. Once again, SJSR patients at the site of Kleinman’s original study in Hunan were assessed and re-diagnosed using the DSM and the ICD.\footnote{Doris F. Chang et al., “Shenjing Shuairuo and the DSM-IV: Diagnosis, Distress, and Disability in a Chinese Primary Care Setting,” Transcultural Psychiatry 42, no. 2 (June 2005): 204–18, https://doi.org/10.1177/1363461505052660. This study was actually conducted from 11/1997 to 08/1998, but was later published in 2005.} Chang et al. found that SJSR correlated best with an ICD diagnosis of neurasthenia, with the ICD “being more specific to subjects with prominent and persistent symptoms of fatigue”, while the closest DSM counterpart was undifferentiated somatoform disorder.\footnote{Ibid., 209.} Researchers concluded that there is “continued phenomenological and clinical significance of shenjing shuairuo among rural
Chinese patients despite its increasing marginalization in professional psychiatric discourse” and “that there may be therapeutic benefits to retaining [SJSR] at least in the immediate future”.  

In the midst of these types of efforts to determine equivalencies, researchers again looked toward a possible relationship between American definitions of CFS and Chinese experiences with SJSR. Writing in 2001, Lin et al. reported findings from a multi-site study undertaken in Los Angeles, Hong Kong, and Changsa, China. They found that overlap with ICD neurasthenia and DSM categories (other than somatoform disorders) was limited, with 78 percent of neurasthenia patients not meeting criteria for depression, anxiety, or other DSM diagnosis. A parallel study including Caucasians from LA also found that more Caucasians with primary complaints of chronic fatigue met criteria for ICD neurasthenia than they did for CDC-CFS. The researchers concluded:

Symptom profiles of neurasthenia are strikingly similar among patients studied at divergent sites, even between the Chinese neurasthenics and the non-Chinese patients who fulfill criteria for CFS, suggesting the consistency and coherence of a discrete psychiatric condition. For the Chinese-Americans in the Greater Los Angeles metropolitan area, the prevalence of the syndrome exceeds all other psychiatric conditions. For the Los Angeles Caucasians, chronically fatigued patients had symptoms which fulfilled the criteria for neurasthenia better than criteria for CFS. At variance with the prevailing ideas of many clinicians and researchers that neurasthenia and CFS represent a form of depression or anxiety disorders, masked with somatic presentations, our data indicate that neurasthenia and CFS are essentially distinct from depression and other psychiatric diagnoses defined by the DSM system.

While the SJSR/CFS inquiry continued, some researchers turned to examinations of neurasthenia from the perspective of infectious disease. In addition to listing fatigue syndrome under the rubric of neurasthenia, ICD-10 also allowed for the diagnosis of a postviral fatigue syndrome, which it also calls benign myalgic encephalomyelitis (code G93.3). Recall that one of the etiological considerations for what was causing these fatigue syndromes even before the CDC published its definition in 1988 was Epstein-Barr virus (EBV). First identified in 1964, EBV is a

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616 Ibid., 214–15.
618 Ibid., 74–75.
ubiquitous virus most readily known for its causal role in mononucleosis, and it was first isolated from Burkitt lymphoma cells.\textsuperscript{619} It is now known to infect nearly ninety percent of the world’s population and to be involved in many diseases.\textsuperscript{620} Although researchers in the West never really fell upon many convincing results, there had been some effort in the 1990s to implicate EBV as a causal factor for chronic fatigue.\textsuperscript{621} Similarly, some Chinese researchers also wondered if EBV could be implicated in SJSR cases.

From May to October of 2000, Cao et al. studied thirty-four SJSR patients who were paired with thirty-three controls matched for age, gender, and educational levels at the Hunan, Xianya Hospital were Kleinman’s original study occurred decades earlier.\textsuperscript{622} Serum gamma G immunoglobulin (IgG) and gamma M immunoglobulin (IgM) for Epstein-Barr virus were compared between groups as was serum presence of the viral DNA. While the positive percentage of EBV IgG was significantly higher in SJSR patients (76\% vs. 52\%, p=0.033), the geometric mean titers were not. IgM was positive in eight cases (indicating recent infection), and none were positive in controls. Unsurprisingly, there were no other significant findings. Still, researchers concluded that neurasthenia may be related to EBV infection.\textsuperscript{623}

At the end of the decade, Cao et al. published again on the subject in a paper titled “Psychosocial and Immunological Factors in Neurasthenia”.\textsuperscript{624} This time they studied thirty patients meeting criteria for ICD neurasthenia and matched them with thirty controls. In addition to serum IgG and IgM, all participants were also measured using the SL-90 symptom checklist, Eysenck personality questionnaire (EPQ), and a life event scale.\textsuperscript{625} They found that neurasthenia patients had higher EPQ scores for neuroticism and introversion and a higher number of stressful


\textsuperscript{623} Ibid., 17: “由此可见, EBV 感染与神经衰弱的症状之间可能存在某种关系”.


\textsuperscript{625} The Eysenck scale is a T/F self report that measures personality across traits such as extroversion/introversion, neuroticism/stability, and psychoticism/socialization. The life events scale gives a score based on the number of stressful life events. SCL-90 was mentioned above.
life events. Neurasthenia patients also had higher serum IgG (23 patients positive vs. 15 controls, p<0.01) and IgM (8 patients vs. 0 controls). With comparable immunoglobulin findings to their early study, the researchers concluded that the personality and stress scores may indicate a possible mechanism whereby EBV is more easily activated under stress conditions, leading to symptom manifestation. While the study is interesting, it is hardly convincing evidence that SJSR is related to viral infection, and with no meaningful findings relating to EBV or chronic fatigue syndrome, the decade did not really bring anything approximating closure to the tension between Western psychiatry’s dismissal of SJSR as a category and Chinese continued recognition of its usefulness.

Writing in 2007, Lee and Kleinman coauthored a paper titled “Are Somatoform Disorders Changing with Time? The Case of Neurasthenia in China”.626 Readers of that article should be struck immediately with the conceptual difficulty that continues to linger over attempts to fit SJSR into DSM categories, insofar as it is not clear whether the title aims to position SJSR as a somatoform disorder, depression, or a somatoform depression. In any event, the authors suggest that the “changing with time” can be seen across three distinct periods. First, they suggest that the “prereform period” before 1980 was one where SJSR was a generic neurotic category that included depressive and anxiety disorders. Second, the “reform period” from the 1980s to 1995 saw the “impact of DSM-III and Kleinman’s study”.627 Finally, the “postreform period” after 1995 is called the “burial of neurasthenia”, which is framed as a new period where “those who do diagnose neurasthenia may be considered outdated if not deficient in clinical skills”.628 Despite these claims, researchers have still made efforts to study SJSR/neurasthenia as conceptual categories that continue to capture the experience of countless people. In addition to the research cited in this chapter, young clinical researchers also made it the subject of numerous Master and Doctoral level theses.629

627 Ibid., 848.
628 Ibid.
629 Doris Fu-Ping Chang, “The Cultural Validity of Neurasthenia: Psychiatric Diagnosis and Illness Beliefs in a Chinese Primary Care Sample” (Ph.D., University of California, Los Angeles, 2000), http://search.proquest.com/pqdt/docview/304583304/abstract/F2446E3F7364E07PQ/2; Kit Ching Wong, “Psychometric Investigation into the Construct of Neurasthenia and Its Related Conditions: A Comparative Study on Chinese in Hong Kong and Mainland China” (PhD diss., The Chinese University of Hong Kong, 2008), http://search.proquest.com/pqdt/docview/304831434/abstract/F2446E3F7364E07PQ/1; Andrew George Ryder, “Cross-Cultural Differences in the Presentation of Depression: Chinese Somatization and Western
In the same year that Lee and Kleinman were describing the three eras of neurasthenia’s transformation, Kleinman was preparing a preface to the text that was claimed to have initiated the “reform era”. *Social Origins* was going to be published in Chinese for the first time in 2008, and there needed to be a new, Chinese preface written for the occasion. As a conclusion to this chapter it is worthwhile looking at and citing at length that preface intended for the Chinese reader, as it brings into focus some of the overall contentions of this project.

After some preliminary remarks about his choice of title and avoidance of the formal category of posttraumatic stress disorder when describing the trauma of SJSR patients who lived through the Cultural Revolution, Kleinman turns to the controversy that his book instigated. The problem, he suggests, is that some psychiatrists in China misunderstood his intention when they felt that he was criticizing them for uncritically lumping a variety of psychiatric patients under the label SJSR and failing properly to recognize and diagnose depression and anxiety disorders. Regarding this, he states that such was never the point of view that he wanted to express. Rather, regardless of whether it was SJSR, depressive disorder or anxiety disorder, all should be recognized as cultural concepts, and cultural concepts shape the actual physiological experiences and establish the boundary separating normal and pathological states. The cultural concepts influence the professional diagnostic system: professional diagnostic systems also have historical, sociological, political science, and economic backgrounds. These cultural conceptions are also part of the cross-national mobility of ideas, products, and people. This flow did not have a clear name to describe it in the 1980s, but now we all refer to it as ‘globalization’. Finally, I want to say that these rooted concepts exist in the network of personal and collective meanings. These kinds of meaning networks link together people, institutions, social events, and stressors of life. I refer to this type of linkage as ‘sociosomatic relationships’.

After such a conciliatory explanation of his work suggesting that he had not taken a stance regarding the validity and accuracy of Chinese diagnosing practices, he continues with a paragraph...
that seems very much to affirm the concerns of his interlocutors in the neurasthenia/depression controversy. He writes,

There is a theory regarding the relationship between authors and readers that maintains that when a work is published, regardless of the original intention of the author, the reader will understand it as he wishes. Because of this, the book has attracted the attention and discussion of the Chinese medical community. Discussion has primarily involved the debate as to whether SJSR is a kind of authentic or true disease, and whether a patient with SJSR is really trapped in depression. Ten years after this book was published, these discussions finally have a conclusion. The young generation of researchers believe that if the latest professional standards and facilities are used, patients with SJSR in China can be diagnosed with depression. Some pharmaceutical companies have also quoted my research findings to assert this view, and to confirm that patients with depression had not received the proper diagnosis and treatment.\textsuperscript{632}

It seems a very dubious practice to suggest that one’s position in a debate is validated by the fact that pharmaceutical companies have found your position to be economically favorable. Instead, it seems more reasonably to be a matter that ought to make those involved in the debate wonder if some of the interested parties would benefit by the “burial of neurasthenia” and by the convergence of how mental health concepts and psychiatric symptoms are experienced, viewed, and address worldwide. Whether or not we will eventually see the globalization of the American psyche, with the concomitant homogenization of illness manifestation and experience, is a question that only time will tell; there has been no shortage of efforts at bringing about such a change.\textsuperscript{633} However, if neurasthenia had been buried since 1995, it was to be resurrected in the following decades. In the next chapter, I will briefly address some continuing inquiries regarding SJSR, and will summarize and conclude this project.

\textsuperscript{632} Ibid., 2: “有一种探讨作者与读者关系的理论认为,一部作品一旦发表,不论作者的原意是什么,读者都会把它理解为自己所希望的那样。正因为如此,本书引起了中国医学界的关注和讨论。讨论涉及神经衰弱是否是一种真正的疾病,神经衰弱病人是否受困于抑郁症。本书出版十年后,这些讨论终于有了结论。年轻一代的研究者认为,如果使用最新的专业标准和设备,中国的神经衰弱病人可以被诊断为抑郁症。一些医药公司也引用我的研究发现来陈述这一观点,并且以此证实抑郁症患者没有得到应有的诊断和治疗”。This last sentence is not clear. It reads, “and to use this to confirm that depressed patients have not received proper diagnosis and treatment”. If this was his intention it is even more dissonant with the earlier paragraph of his preface cited above. A more charitable translation (based on the assumption that he has made an error in the Chinese) would be, “... and use this to confirm that they will receive...”. Unfortunately, that does not appear to be what is written.

\textsuperscript{633} Watters, \textit{Crazy like Us}. See Watter’s discussion of GlaxoSmithKline’s efforts at bringing Laurence Kirmayer on board for the popularizing and making socially palatable the concept of depression in Japan.
Chapter 6: Conclusion

Over the past five chapters, I have attempted to demonstrate that it is inappropriate to conceptualize SJSR phenomenologically, and nosologically, by framing it as a somaticized form of some other known entity. Any understanding of the SJSR experience must take into account that the worldwide population of Chinese speakers went from a state of having no such category to one in which a category appeared that clearly delineated a form of experience with which they could identify and for which they could seek help. What’s more, the transition from one state of affairs to the other took place over a rather short interval of time, approximately two decades (1900–1920). Chapter 3 recounted part of the process of SJSR’s entrenchment into the Chinese lexicon and the growing awareness of its phenomenology among the Chinese people. Such a background is a necessary starting point for understanding how people came to know about, conceptualize, and believe in the reality of SJSR as illness. The initial interpretation of their experience, which later morphed into the NCCP, was discussed in Chapter 4, with all the original papers and arguments that constituted the Western view of SJSR at that time. In its original form, the idea that Chinese speakers suffered from a poverty of language, which constrained their ability to describe emotional experience, has long since been condemned to the dustbin of intellectual history. Such explanations are now recognized as evincing a deep ignorance of the profound, emotionally descriptive complexity of the Chinese language and its family members, like Hokkien. Alternatively, such explicit claims as were made in the 1980s might instead be seen as evidence of overly hasty attempts at explanation. Either way, it is unfortunate to see that the poverty of language argument has resurfaced in new garb in recent years, which I will consider shortly.

In the decades after 1980, disagreeing parties continued to grapple with the idea that Chinese people “somatize” their emotional distress, and SJSR was the subject of a great deal of research and debate, as I have attempted to demonstrate. The previous chapter recounted the “neurasthenia-depression controversy” through the first decade of the twenty-first century. Although some parties have claimed victory in that debate, the changes that continue to occur in China and the research that continues to be undertaken worldwide will only very slowly demonstrate that the controversy was itself a false dichotomy. The rise of depression in China is precisely analogous to the rise of SJSR many decades earlier. That is to say, depression is now becoming a viable category of experience in China to which people can consciously or
unconsciously conform. The irony is that those who claim victory in that earlier debate are seemingly unaware of their own role in shifting emphasis from one form of experience to another via, at the very least, their influence on psychiatric practice.

In an effort to bring this project to conclusion, I hope to accomplish five tasks in this final chapter. Briefly, I will (1) show some examples of the refurbished “poverty of language” argument, which is being used to interpret the changing incidence of “depression” in China; (2) point out an ongoing line of inquiry into the subject of “somatization” among Asian peoples; and (3) introduce the reader to a diagnostic issue in Japanese psychiatry, which very much appears to be the retention of a conceptual category accounting for clinical phenomena that lie within a realm of experience where the “neurasthenia-depression controversy” can persist. With these issues in mind, I also aim to (4) draw on some fascinating research from cultural neuroscience in order to offer a cursory explanation for how people can draw from available conceptual categories in ways that transform into embodied experience. Last, (5) I will offer some final thoughts in light of everything presented throughout the course of this project.

6.1 Poverty of Language Revised

In 2011 the book *Deep China: The Moral Life of the Person, What Anthropology and Psychiatry Tell Us about China Today* was published. The fifth chapter of that text was authored by Sing Lee, whom we have encountered numerous times above. He aimed in the chapter to discuss “how emotional expression, mental disorder, and sociopolitical context interrelate in Maoist and post-collective China”. Specifically, his claim is that “repression of emotions during the Maoist period promoted neurasthenia as a popular physical idiom of distress and a ubiquitous medical diagnosis”. For several pages immediately following this claim, Lee describes to his readers that, as an aspect of Chinese culture, “inner feelings and their outward expressions can be cautiously controlled and distinct in Chinese people . . . by holding their feelings back, Chinese people may even appear to deny their emotions”. This chapter leaves one with the glaring question as to whether Lee wants to attribute the repression of emotional expression to Maoism, to Chinese

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635 Ibid. Take careful note of the claim; namely, “repression of emotions during the Maoist period” is the focus of explanatory power.
636 Ibid.
culture itself, or a combination of both. In any case, with respect to SJSR, the informed reader will recognize that Lee is presenting a reformulation of Kleinman’s (and by extension Leff’s) foundational claim regarding the nature of Chinese language and emotional expression. Of course, authors have reasonably moved away from the idea that the Chinese language is “relatively impoverished in psychological terminology”. Instead of attributing the symptomatology to linguistic constraints and lack of vocabulary, cultural psychiatrists began claiming that culture itself shaped, regulated, and constrained affect, which is obviously true to some extent. The claim that Chinese somatize because that is just what they do, however, does not leave much room for further discussion. Ultimately, Lee’s claim, drawing on Kleinman’s ethnographic work with people who survived the Cultural Revolution, ends up being a refurbished form of the original argument. In other words, Chinese somatize not because their language is deficient and they do not know how to psychologize; they somatize because they were not allowed to psychologize. Emotional repression under a political regime led to a poverty of expression.

To remove any doubt that this is the claim, the reader can see from the conclusion of that chapter how the position is restated. He writes: “Although the Chinese Communist regime remains a dictatorship, it has expanded individual liberty in multiple recognizable ways . . . For one thing, interpersonal communication can be expected to become increasingly expressive of feelings. These feelings will become ever more discriminating, especially among younger and middle-class individuals”. One of the implications of this change, he claims on the next page, is the “finding of rapidly increasing rates of depression in community epidemiological surveys”. We may be willing to grant that increased psychologizing in the context of a multiplicity of influences from Big Pharma, Western psychiatry, international digital media, and others can facilitate changes such that rates of depression on epidemiological surveys increase. It does not follow from this, however, that among Chinese people, the long history and resonance of SJSR specifically, and somatic presentations generally, resulted from repression of emotions during the Maoist period. This type of sociological deus ex machina has appeared before in the writings of the NCCP, with references

639 Ibid., 206.
to the influences of Soviet Psychiatry, Pavlov, and the trauma of the Cultural Revolution as putative explanations for why neurasthenia became entrenched in China.\textsuperscript{640}

The obvious problem with all such just-so explanations offered for neurasthenia’s resonance with the Chinese people is that they fail to address the fact that the phenomenon took hold not only in Mainland China but in a host of other places. Neither Soviet psychiatry, Mao, Pavlov, the initial “poverty of language” argument nor the repression of emotion during the Cultural Revolution offer any explanation of the domestication of neurasthenia in Japanese society for over half a century. Even though Kleinman began his career claiming that neurasthenia in Taiwan could be accounted for by the poverty of the Chinese language, it is still the case that Mao, the trauma of the Cultural Revolution, et cetera offer no explanatory value in the case of Taiwan. Such is also clearly true if we consider Hong Kong or generations of Chinese living overseas in places like Vietnam, Singapore, or anywhere else in the world. In short, the idea that Maoist repression or social trauma from the Cultural Revolution offers explanatory power for why neurasthenia took hold, resonated, became entrenched, was accepted, or was popularly used as a conceptual category in China is simply untenable. After all, Lee begins his chapter with a citation stating that \textit{Mao himself suffered from SJSR}. Mao certainly did not develop SJSR as a consequence of the repression of emotion during the Maoist period, nor did “repression of emotions during the Maoist period promote neurasthenia as a popular physical idiom of distress and a ubiquitous medical diagnosis” for Mao Zedong himself. Such a claim, when made explicit, appears very much nonsensical. My contention here in no way dismisses the role of political institutions in shaping and regulating the emotional lives of citizens. In this instance, however, the principle of parsimony ought to lead us very seriously to suspect any explanation offered for one locale that does not apply to another, especially within the Chinese-speaking world. Furthermore, rather than viewing Maoist repression of emotion and cultural trauma as causal forces facilitating somatization at the expense of psychological expressivity, parsimony ought to suggest to us that such historico-cultural events served as \textit{sources for deep impairment} that could then manifest in a manner consonant with both human biology and the beliefs of a population for whom a salient category was available. Maoist repression did not promote neurasthenia for Mao or for Lu Xun, and insofar

\textsuperscript{640} Pavlov and later Soviet psychiatry feature in the first chapters of \textit{Social Origins}. The Cultural Revolution appears later in that book as well as in \textit{Culture and Depression}.  

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as it did promote SJSR for others, such was the case only as a consequence of the antecedent cultural and historical factors that made SJSR a possibility of human experience in the first place.

In like manner, recent increases in epidemiologic rates of “depression” in Chinese society can similarly be explained by the shifting modes of experience that have become viable for Chinese citizens. In other words, depression is an experiential category that has been introduced and marketed to the Chinese people in recent decades, and as long as Chinese people continue to conceptualize their “problems of living” within the available discourses of depression, it should not be surprising to see rates of depression increase. This in no way implies that suppressed or repressed emotional content constituting a previously somatized “depression” is now being given a voice. Instead, we might better conceive of the recent situation as a repetition of the past; that is to say, once again, an imported category is being deeply internalized and is giving shape to those most challenging of human experiences.

Recent efforts at understanding the Mainland Chinese experience of “mental health” have borrowed from the same idea that China has gone “[f]rom somatization to the emphasis on psychological and emotional health”. Anthropologist, Jie Yang, points out that “Arthur Kleinman examines the prevailing neurasthenia in China as a possible ‘somatization’ of depression in the aftermath of that tumultuous period”. Today, she claims, “people express mental health concerns both somatically and psychologically, rather than exclusively somatically, as often was the case prior to, during, and after the Cultural Revolution”. While it is not at all clear that Chinese people ever “exclusively” expressed their concerns somatically, it is encouraging to see that Yang recognizes the presumed dualism of such concerns. She further points out that the idea of somatization exists within a dichotomous relationship that in some ways may be imposed on Chinese people by researchers who overlook the psychosomatic unity of experience. Kleinman’s emphasis, she reminds us, was an attempt to explore “the social conditions that encouraged the somatic articulation of distresses”, but “[o]ther lines of inquiry about somatic complaints deriving from possible psychological or psychiatric disorders address the cultural habitus of

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642 Yang, *Mental Health in China*, 34.

643 Ibid.

644 Ibid.
undifferentiating body from mind in Chinese medical contexts”. She does not find it necessary to make clear or criticize the fact that Kleinman’s exploration has resulted in and concluded with claims about the unavailability of psychological articulations. His attributions, discussed in the preceding paragraphs and chapters, do not really give an account for the traction neurasthenia has had in Mainland China, Hong Kong, Taiwan, Japan, overseas Chinese communities, Europe, India, and the USA. She also does not address the fact that “depression”, the clinical and conceptual category as it is currently being conceived, is an importation that is being domesticated in a way not altogether unlike the domestication of SJSR one hundred years ago.

6.2 Ongoing Somatization Research

In this section, I do not intend exhaustively to review the recent, ongoing research regarding somatization that has continued into the second decade of the twenty-first century. Instead, my aim is simply to make clear to the reader that such efforts are continuing, sometimes repeating various approaches, such as considering the pragmatics of the sick role, externally oriented thinking and alexithymia, the role of stigma, and similar paradigms that have already appeared above. Other researchers have attempted to transcend the limitations of these explanations for somatic symptom presentation by generating new models of cultural psychology.

From a checklist-psychiatry perspective, some clinicians find somatization to be an interesting topic of inquiry with implications for recent changes to DSM-5 “Somatic symptom and related disorders”. Representatives of this type of writing continue to rely on prior explanations for the findings that “somatic manifestation is common in the Asian population”, explaining the phenomenon by suggesting that “cultural factors” restrict discussion of psychological issues, the high “level of stigma associated with mental disorders in Asian countries”, and the “role of somatic symptoms as an idiom for help-seeking”.

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645 Ibid.
646 With respect to Europe and the USA, I should point out that neurasthenia has had different historical levels of traction. It is still used in the ICD and resonates with people in Eastern Europe and Russia. Though it does not currently resonate in the USA, it certainly did for some time, and something similar to it likely will resonate in future.
An interesting and unique means of approaching somatization can be found in efforts at parsing the difference between somatic awareness and interoceptive accuracy. A brief survey of some of this work can be found in review by Ma-Kellams (2014); the main idea is that somatic awareness and interoceptive accuracy are distinct, the former being driven by cultural schemas while the later is constituted by bodily cues.\(^{648}\) The increasing complexity of research in this area takes very seriously the historic claim that disparate cultural groups experience bodily sensations and emotions differently, and there is a growing awareness in the neurosciences that interoceptive mechanisms make subtle contributions to the experience of emotion.\(^{649}\)

Among the more interesting approaches in the ongoing research into somatization are those found in the writings of Ryder, Chentsova-Dutton, Dere, and their collaborators, which were introduced in the previous chapter. I raise them again here to point out some of the advances in thinking about somatization that they achieved after 2010. First, they seem to have been able to put to rest most concerns about the utility of alexithymia in regard to Chinese patients’ tendency to describe physical symptoms as chief complaints. Specifically, Dere et al. considered alexithymia by looking at the discrete constitutive constructs of “externally oriented thinking” (EOT), “difficulty in identifying feelings” (DIF), and “difficulty in describing feelings” (DDF). They found that in outpatient samples in China, EOT was negatively predicted by scores on self-report scales for modern and Euro-American values, using scales designed to weigh self-identification with various clusters of traditional versus modern and Euro-American versus Asian values. DIF and DDF were not predicted by such scales.\(^{650}\) The implication was that the higher the levels of identification with modern and Euro-American values, the less likely one is to engage in externally oriented thinking.\(^{651}\) Second, as briefly mentioned in the previous chapter, they have helped to show that instead of “somatize” (as a verb or in its noun form), in the Chinese context, it is more useful to speak of physical or emotional descriptions of patient experience; that is, there is no need

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\(^{651}\) The complicated details behind the EOT construct and its psychometric validity are beyond the scope of this discussion.
to use the theory-laden term “somatization” as it implies the conversion of affect into physical complaint as a result of an inability or unwillingness to articulate affect in affective language.\footnote{Andrew G. Ryder and Yulia E. Chentsova-Dutton, “Depression in Cultural Context: ‘Chinese Somatization,’ Revisited,” The Psychiatric Clinics of North America 35, no. 1 (March 2012): 24, https://doi.org/10.1016/j.psc.2011.11.006. This model is very rich and cannot be described in passing. It does approach the type of cultural shaping of experience that I mention below.}

Along these lines, they have argued for a culture-mind-brain model of experience that is always functioning in unity. “At the brain level, the body continually relays and receives signals to and from the brain, which monitors sensory inputs, integrates them, and maintains a dynamic representation of the state of the body . . . At the mind level, emergent conscious representation of the body integrates sensory and hedonic inputs with conceptions of normative and non-normative bodily responses . . . At the culture level, sufferers draw on the large but finite pool of possible responses to profound distress”.\footnote{Ibid. I am overlooking their use of the term “emergent consciousness”, which is itself highly contested and a source of rigorous debate in philosophical literature.} Symptoms arise out of the continual actions of these three aspects of the person and are regulated by the dynamic nature of remembering, responses from others, and input from socio-cultural norms. Unfortunately, their attempts to deepen this approach may be affected by their own act of referencing their model as a “propos[al] that Chinese somatization can be understood as a cultural script for depression”.\footnote{Xiaolu Zhou et al., “From Culture to Symptom: Testing a Structural Model of ‘Chinese Somatization,’” Transcultural Psychiatry 53, no. 1 (February 2016): 3–23, https://doi.org/10.1177/1363461515589708.} Furthermore, it does not help their credibility on the subject when they make claims such as that SJSR was “[o]riginally described by Beard in the United States, [and this] diagnosis was adopted first by Pavlov and then introduced to China by Russian psychiatrists after the 1949 revolution”.\footnote{Ryder and Chentsova-Dutton, “Depression in Cultural Context,” 18.}

Despite attempts at sophisticated explanations for the divergences of symptom presentation often observed in comparisons of American and Chinese patients, in clinics or while in psychiatric care, it is unfortunate that these authors have themselves fallen into the larger hermeneutic frame that was set up by the NCCP in its earliest interpretations of these phenomena. This can be most clearly seen in the 2016 review paper by Sun and Ryder.\footnote{Jiahong Sun and Andrew G. Ryder, “The Chinese Experience of Rapid Modernization: Sociocultural Changes, Psychological Consequences?,” Frontiers in Psychology 7 (April 5, 2016): 477, https://doi.org/10.3389/fpsyg.2016.00477.} The aim of the paper is stated to be an exploration of the psychological implications of sociocultural transformation in China since the 1980s, with a specific focus on two issues: 1) social and developmental psychology research
demonstrating increasing adherence to individualistic values, and 2) psychiatric epidemiological research demonstrating increasing prevalence of depression in China. Analyzing these two phenomena together, the authors intend to lay out several conceptual hypotheses that can account for (2) in the light of (1). I list their hypotheses below so that the reader can more readily see what has not been considered. In their final section titled “The ‘Unleashing’ of Emotion in China”, we unsurprisingly find seven references to Kleinman (1981,1995), Lee (2011), and Yan (2003), all of whom have been mentioned above and who have suggested that there has been an “unleashing of emotions” in China since the open-door policy of Deng Xiaoping. With this in mind, the rising rates of depression in China are then attributed to the following possibilities:\textsuperscript{657} 

1) Problematic aspects of a shift toward individualism. 
2) Problems arising from large amounts of internal migration and socioeconomic dislocation. 
3) Problematic nature of the rapidity of China’s change. 
4) Changes in emotion norms that have altered which experiences are more salient. 
5) Changes in societal attitudes toward mental illness and decreased stigma such that people are willing to express and discuss more. 
6) In the context of the “ever increasing influence of mainstream Western psychiatry”, there may have been changes in training of mental health professionals and alteration in diagnostic practice. 

We can see that item (1) is an example of culture itself being “pathogenic”, this phenomenon was briefly mentioned in Chapter 1 above. Individualism may simply lead to the experiences that we label depression. Items (2) and (3) are attributions external to the person whereby difficult social factors might facilitate experiences labeled depression. Item (4) is the main issue arising out of Lee’s claims (drawing on Kleinman) mentioned earlier in this chapter. More will be said of this momentarily. Item (5) assumes “concealment of emotion” due to stigma. I have argued throughout this project that concealment is an inadequate interpretation of somatic symptoms. Item (6) attributes depression prevalence to changes in diagnostic practice. This is certainly at the heart of this whole project, and we should expect this impact to grow, especially since DSM-5 does not even require sadness or depressed mood for the diagnosis of depression.

\textsuperscript{657} These are all offered, nearly verbatim, on page 9 of their article.
An interesting thought experiment in this regard would be to modify the timeframe and ask about the social change and prevalence of SJSR from 1900 to 1920. With some minimal modification to a few of these items, and leaving some the same (3, 5, and 6), one could come to the same conclusions. In fact, that appears to be pretty much how SJSR has been viewed by cultural psychiatry over the years. What is obviously missing is an item (7); namely, there was an introduction of an imported conceptual category that took on cultural salience, creating a symptom pool towards which people could consciously and/or unconsciously conform. Rather than reify depression, one might view it in the same way. I conclude this section with a quote from Sun and Ryder, which betrays the fact that they take depression, to some extent, as the supraordinate category of experience in their research. They write:

With shifts in cultural values that reflect increasing individualism, we might expect changes toward a more self-focused thinking style, such as rumination, and increasing openness to the use of psychological language when reporting depressive symptoms. Moreover, increasing attention to internal psychological states might shape the very experience of depression, so that an increasing number of people in China suffer from psychological symptoms when depressed.\textsuperscript{658}

I suggest replacing the term “depression” here with some term that does not assume the prior ontology of the depression category. Given the influence of Western psychiatry (6), the influence of pharmaceutical expansion and cultural media (all impacting item 4), and the introduction of an imported conceptual category that took on cultural salience and creating a symptom pool towards which people could consciously and/or unconsciously conform (7), one ought not be surprised to find “an increasing number of people in China that suffer from depressive symptoms when distressed”.\textsuperscript{659}

6.3 Diagnostic Issues in Japanese Psychiatry

While SJSR began as a Japanese neologism introduced into China through print and the minds of Chinese intellectuals who had studied in Japan, the Japanese story of neurasthenia took a different trajectory than the Chinese one. The research and debates that I addressed in Chapters

\textsuperscript{658} Sun and Ryder, “The Chinese Experience of Rapid Modernization,” 9. Reporting depressive symptoms need not be the same as reporting symptoms of depression.

\textsuperscript{659} This last quotation is my modification of the final sentence in their quotation from page 9.
4 and 5 have not had analogous counterparts in Japan. Part of the reason for this difference is that Japan abandoned the category of neurasthenia rather early when compared to China. Japanese people are familiar with the term, but it does not carry anything like the cultural capital that it continues to in China, Hong Kong, and Taiwan. Abandonment of the category occurred in an informal sense with the changes in practice that accompanied the embrace of the ICD and the DSM. This story is a complicated one, and I will not tell it in detail here. Instead, I want to introduce the idea that, although neurasthenia was in some sense abandoned by Japanese psychiatry around the time of DSM-III’s introduction to Japan, almost immediately alternative categories were available to take over the cultural work for which neurasthenia had previously done.

Some scholars have written: “In the 1960s, neither the ICD nor the DSM was used in psychiatric diagnosis in Japan”\textsuperscript{660} With the publication of DSM-III in 1980, Japanese scholars undertook translation of the text, with a completed translation becoming available in 1982. This does not mean, however, that Japanese clinicians began using the American diagnostic system, although many academics did use it for research purposes. Still, during the 1980s there were numerous studies by Japanese scholars that investigated the facility of the newly translated diagnoses and the measurable reliability of diagnosis between different users of the manual.\textsuperscript{661} Regardless of reliability issues, which were favorable, many Japanese psychiatrists resisted its use, preferring their own etiologically informed diagnostic language that drew on the German psychiatry that first took root in Japan. “Compared with American psychiatrists who have been familiar with the concepts of ‘somatization’ and ‘somatoform disorder’ since the publication of the DSM-III (1980), it was not until the late 1990s when Japanese psychiatrists started using these terms”.\textsuperscript{662} Kitanaka Junko wrote that as late as 1997 she encountered “hardly any psychiatrists . . . at prestigious institutions” that regularly consulted the DSM.\textsuperscript{663} However, by the year 2000, she reported that most “depression experts” were using the manual, and that it had “become a fact of


\textsuperscript{663} Kitanaka, \textit{Depression in Japan: Psychiatric Cures for a Society in Distress}, 53.
everyday clinical practice, there to stay, despite the lingering skepticism”.\textsuperscript{664} While younger Japanese psychiatrists are familiar with and use DSM criteria, some studies suggest that clinicians over age forty do not really employ the system.\textsuperscript{665} Even today, “[t]he Japanese Government uses classifications from the tenth revision of the ICD to categorize disorders and determine treatment fees”.\textsuperscript{666} All of this is to say that the waning of neurasthenia in Japan did not occur overnight as its formal existence did in the USA. Its disappearance from the DSM did, however, play a role in Japan in a manner not seen in China. Its retention in the ICD does not appear to have been a strong enough reason to continue widely applying the diagnosis. Perhaps the fact that it was absent in the DSM had something to do with this, even though the DSM was not openly embraced. If such was the case, it might explain why a less obviously controversial diagnosis at the time might have served as a proxy for the DSM-defunct category.

Kitanaka Junko suggests that in the long evolution of psychiatry in Japan, psychosomatic medicine made continued use of the concept of neurosis, while those in the biomedical schools of psychiatry “retained the ambiguity of shinkei by using notions such as autonomic nervous system disorder (jiritsu shinkei shicchosho) that simultaneously denotes both biological and psychosocial implications”.\textsuperscript{667} Her view on this matter appears to be consonant with the findings of other scholars. Writing about her fieldwork on women and menopause in Tokyo from 1980 to 1983, Nancy Rosenberger has described how jiritsu shinkei shicchosho (JRSK) was ubiquitously employed as one way of classifying various menopausal symptoms.\textsuperscript{668} Although describing the negotiations between patients and physicians in the context of the very specific types of symptoms that accompany menopause, Rosenberger highlights the manner in which, for a number of reasons, the concept of JRSK is resonant with Japanese. She believes that the vagueness of the concept, while grounded in the physiology of the peripheral nervous system, “reverberates with other voices in their folk-experience ideas about health, sickness and maturity stemming from Japanized versions of East Asian Medicine”, as well as late nineteenth century ideas pertaining to the

\textsuperscript{664} Ibid.
\textsuperscript{665} Someya, Takahashi, and Takahashi, “Is DSM Widely Accepted by Japanese Clinicians?,” 445.
\textsuperscript{666} Kuroki et al., “Current Viewpoints on DSM-5 in Japan,” 371.
\textsuperscript{667} Kitanaka, Depression in Japan: Psychiatric Cures for a Society in Distress, 38. See footnote 10.
“nervous type” *(shinkeishitsu)*. Physicians writing in popular media could readily shift between usages of JRSK that implied both the deeply physiologic aspects of the person as well as the personality and psycho-social aspects. In all four study cases of her interaction with physicians, JRSK was acknowledged to carry the implication of mental disorder. All of the patient perspectives likewise viewed JRSK as being embodiments of some underlying psychosocial perturbation in the lives of the patient. Fundamentally, the category served to eliminate a strict mind-body dichotomy. The availability of the category bridged layers of explanation for both physicians and patients alike.

The use of JRSK as described above has not proven to be uncontroversial, however. Writing in 1994, Okada and Minoshita submitted a letter to the editor of Clinical Autonomic Research titled, “Functional dysautonomia: a valid clinical entity or pseudo-science?” In their letter, the authors bemoan the fact that “[p]hysicians in almost all areas of medicine in Japan diagnose patients with a malady . . . [that] has been thought to be based on difficulties of regulation throughout the autonomic nervous system stemming from instability in the system, or resulting nervous lability”. They argue that in all the sixty years of combined practice, they have never seen a case of someone diagnosed with JRSK that could not be re-diagnosed with another category of disease, including organic illness, psychological illness, or a combination of the two. Reminiscent of the claims in Chapter 4, they go on to state that JRSK “seems to be a convenient, ‘catch-all’ diagnosis”. They conclude: “We feel that the terms ‘jiritsushkinkei-shicchosho’, ‘functional dysautonomia’ and ‘autonomic nerve dysregulation syndrome’ should be dropped entirely. This flood of what will almost certainly turn out to be pseudo-scientific diagnoses is one of the mysteries of Japanese clinical medicine”. Using just a few representative papers in the controversy, I will point out that there has existed in the Japanese literature a “JRSK-depression controversy” that is somewhat analogous to the SJSR-depression controversy, only the Japanese version has been less controversial.

Just a few years after Minoshita and Okada’s critique, one could find other Japanese clinicians who shared similar opinions. In 1998 Muramatsu Kumiko concluded that general

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669 Ibid., 241.
671 Ibid., 189.
672 Ibid.
673 Ibid.
practitioners in Japan pragmatically use JRSK as a temporary category for those twenty percent of patients with functional symptoms whose complaints are psychiatric in origin but present to a general clinic and require a diagnosis on the basis of a preliminary clinical picture (とりあえずの状態像). However, on the question of whether JRSK should be taken as an individual disease entity, she suggests that doing so will result in the failure to provide both appropriate diagnosis and treatment in regard specifically to the combined bodily and psychic complaints of the patient.

Writing in a special collection of *Stress and Clinical Medicine* in 1999, Itoh Katsuhiro argues that JRSK is a category that is so conveniently employed in clinical practice that it is easily open to the charge of overuse. More specifically, he claims that mild depression (軽症うつ病) is easily mislabeled as JRSK, leading to missed opportunities for early treatment and the potential for rather tragic endings (悲劇的な結末). He concludes that the ease of over-applying the diagnosis of JRSK can confound the true nature of a patient’s illness; “the existence of depression wearing the mask of JRSK is one such example”. It is worth noting that the idea of depression wearing a mask, in both English and Japanese, is merely a reference to the concept of “masked depression”, which is termed *kamen utsubyou* (仮面鬱病) in the Japanese literature. The reader may recall from Chapter 4, that Kleinman’s first major work on SJSR in Taiwan attributed patient symptoms to “somatically masked depressions”. In the case of Itoh, his criticism does not explicitly advocate for the total elimination of JRSK as a diagnostic category, but such opinions can easily be found. However, Itoh does appear desirous to re-diagnose cases of JRSK as depression.

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675 Ibid. “自律神経失調症’を‘ひとつの疾患単位’として使用してしまったと、身体面および精神面の両方の側面からみても適切な診断や治療をはたすことができないことを強調したい”.
677 Ibid., 15. “自律神経失調症’という仮面をかぶったうつ病が存在する、ということもその一例であろう”.
678 See Patients and Healers, 157, 161, 171, 294.
On the other hand, there are those who advocate for the meaningfulness of JRSK as well. In fact, writing in the same special collection as Itoh, titled “General malaise—Life stress of modern people” (1999), Murakami Masato suggests that JRSK is a perfectly acceptable conceptual category as long as clinicians understand what it is intended to reference. He begins by pointing out that in daily clinical practice in Japanese society, JRSK is not used to refer to those “organic forms of autonomic nervous system failure such as Shy Drager syndrome, but as a general term for those functional abnormalities of the autonomic nervous system which manifest as general malaise secondary to psychosocial factors”. As such, there are a variety of clinical phenomena that exist alongside each other, such as general anxiety disorders, depression with anxiety, and other neurotic forms of experience. In the conceptual map shown in Figure 21 below, one can see that depression, neurosis (神経症), and psychosomatic disorders (心身症) all coexist within the broader conceptual category of JRSK.

**Figure 21:** Conceptual map of JRSK in Murakami,1999. JRSK is comprised of multiple various pathologies.

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681 Ibid., 8: “シャイ・ドレーガー症候群のような器質的な自律神経障害は指しておらず、心理社会的要因により不定愁訴を呈した自律神経の機能的異常の総称として使われているのが一般的である”.
682 村上, “古くて新しい病気.” 10 I translate 病態 as “pathology”, but the caption could read, “JRSK is comprised of/comprises multiple conditions”, or some variant.
With this epistemological or nosological orientation, Murakami allows that, for some people, the suprordinate category of experience may very well be JRSK. It appears to be Itoh’s presupposition, however, that depression is the suprordinate concept, with JRSK phenomena as signs and indicators subordinate to the higher order category. Murakami’s thinking is more closely aligned with the nosological features of ICD-10, where section F45.3 makes provision for “somatoform autonomic dysfunction” as a class within the F40-F48 “neurotic, stress-related and somatoform disorders”. That is not to exclude depression as a suprordinate category in its own right. There are instances where such would be the proper conclusion, in which cases ICD section F32 is used to indicate a primary mood disorder. Murakami warns in a section on “easily overlooked depression” that when anti-anxiety medications are unhelpful with regard to the general malaise of the patient, and sleep disturbances are difficult to manage with hypnotics, clinicians would not be mistaken quickly to turn to the diagnosis of depression. Still, the major point here is that one need not run around re-diagnosing all cases of JRSK as depression. Such an act would result from an oversimplification of human experience and a narrow view of nosological hierarchies, and it would evince a desire to lump categories of experience rather than take into consideration the need to split them for various reasons that may manifest themselves.

That JRSK in Japan is a proxy for the abandoned category of neurasthenia is not a very surprising possibility to consider. The fact that such categories are needed to describe those conditions of existence for which standard diagnoses fail to capture patient’s experiences adequately, is a conundrum that will continue as long as categorical and discrete approaches to psychopathology hold sway. Earlier conceptions like “psychophysiologic nervous system reaction” were more open to lines of inquiry that conceived of the person as a psychosomatic unity. Even in the USA, where the DSM predominates, categories like JRSK serve to capture those complaints that do not fit the discrete categories currently available. As such, a popular website in 2018 can publish the views of a physician claiming:

In the 19th century, there was a common medical condition called neurasthenia. Previously healthy people would find themselves suddenly unable to function due to a host of inexplicable symptoms, often including fatigue, weakness, unusual pain that would come and go and move from place to place, dizziness, various gastrointestinal symptoms, and syncope (passing out). Doctors would not find anything to explain these symptoms, so they were attributed to a “weak nervous system”, or neurasthenia.
Women with neurasthenia (men, being men, were usually not given this diagnosis) were often confined to their beds, where they would either recover or eventually die (since prolonged, enforced bed rest is very bad for one’s health). And, while nobody knew what caused this condition, everyone, doctors and laymen alike, took it quite seriously. More specifically, while neurasthenia could not be scientifically explained, it was regarded as a serious condition, and its victims were regarded with sympathy and respect. Most modern doctors who hear about this mysterious condition merely shake their heads in wonder. What, they ask themselves, ever became of this neurasthenia? Few seem to consider the possibility that neurasthenia is still with us. Consequently, they are less capable of recognizing the manifestations of this condition than were their old-time counterparts, and they tend to be far less sympathetic to people who suffer from it. People, who a century ago would have been called neurasthenics, today, are given a host of diagnoses. These include (but are not limited to): chronic fatigue syndrome (CFS), vasovagal or neurocardiogenic syncope, panic attacks, inappropriate sinus tachycardia (IST), irritable bowel syndrome (IBS), postural orthostatic tachycardia syndrome (POTS), or fibromyalgia. Unfortunately, too many victims of these conditions are simply written off as being nuts. They are not nuts. (Or, if they are, it is a coincidence.) Sufferers of all these conditions tend to experience an imbalance, and most often a peculiar volatility, in the autonomic nervous system. This imbalance, which explains their strange symptoms, is called dysautonomia.683

6.4 Cultural Neuroscience

Cultural neuroscience is the study of cultural variation across neural, psychological, and genomic processes with the aim of elucidating the interrelationship among these processes and cultural practices.684 It is motivated by questions of how cultural traits (values, practices, beliefs) influence neurobiology at the level of genetics and neural processes.

It seems universally accepted that life experiences affect the organization and function of the brain. While this is not a controversial or surprising notion, it has very fascinating implications. In order to expand this assumption to its more nuanced form, it is helpful to consider examples.

Neuroscientists have been able to demonstrate that experiences like working as a taxi driver, practicing juggling, or learning a second language result in anatomical changes in the brain. With long-term, professional musicians, anatomical differences are even discernible from coarse visual inspection of images of the brain. Current understandings make such examples of brain plasticity seem commonplace, especially since, in these cases, the physical changes arise directly from the repetitive use of either a language region or a location in the brain affected by the repetitive activity associated with a particular set of motor neurons. The obvious metaphor is that of “growing brain muscle” through repeated use. However, more symbolically associated changes seem less expected.

For example, anthropologists who work in neuroscience have pointed out that watching the victory or defeat of a favorite sports team correlates with significant changes in cortisol and testosterone in a manner that very closely resembles the same changes that occur when dedicated chess players win or lose. In other words, similar biological changes associated with victory or defeat can be mediated symbolically. That is to say, through the internalizing of either chess or a sports game as a meaningful activity, one can elicit a biological response while the other may not. The determining factor is the extent to which either one is symbolically meaningful to the individual. To draw out the significance of this further, a different example might prove helpful.

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Cultural cognitive style has also been investigated in the context of neural representations of self and other. Using psychology constructs of “cognitive framing of self” as either “autonomous” or “inclusive of intimate others,” Zhu and colleagues measured brain metabolic activity via fMRI concurrent with the behavioral task of responding to personal trait adjectives either about oneself or about an intimate other. They demonstrated that ventromedial pre-frontal cortex activity differed markedly when Western participants were responding to self-judgments compared to when the same adjectives were offered in reference to an intimate other—one’s mother, for example. Chinese participants lacked the activation difference, as measured by fMRI. The inference drawn was that previous constructs accurately detect a difference in East/West conceptualizations of self in terms of including or excluding intimate others. In other words, for the American group, “I” did not extend past the self. Whereas “I”, for the Chinese participants, included family members. What was detected behaviorally in evaluations of self or other was reflected in the neural organization of what persons considered to constitute the “self”. More recent work has continued to pursue this line of research, concluding that construals of self are detectable in culture-specific mechanisms among Western and East-Asian groups.

While the construct of “cognitive framing of self” in the previous example is the result of cultural differences that have been internalized over the life-course, major differences in cognitive style and its neurophysiological substrates need not take a lifetime to develop. A most fascinating example can be found in a replication of the study mentioned above (Han, Northoff 2008).

In the replication, all participants were Chinese from the PRC. One group was comprised entirely of non-religious persons, while the corresponding group was made up of Christians who had been part of their religious community for one to seven years. Interestingly, the differences found in the

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695 Han and Northoff, “Understanding the Self: A Cultural Neuroscience Approach.”
original study were repeated in the second study. The Christian group demonstrated brain activity unlike their non-religious counterparts, but very much like the American participants in the early study. The “findings suggest that adopting Christian beliefs may result in weakened neural encoding of stimulus self-relatedness but may enhance neural activity in areas that mediate the evaluative process applied to self-referential stimuli”. Whatever one makes of the researchers’ interpretations, the most obvious implication is that belief itself affects brain activity and organization.

The most well-known example of belief affecting physiology is the placebo effect. Traditionally, the placebo effect has referred to the positive outcomes that result from belief in the efficacy of treatment. Its opposite effect has been called the nocebo effect, and it is characterized as the negative outcome or worsening of symptoms that result from belief that a negative outcome is immanent or unavoidable. Recent studies have demonstrated that expectancy of a noxious stimulus not only increases the experience of pain subjectively, but it increases the afferent pain circuitry in the brain, an effect visible in fMRI. What are the implications of the possibility of belief modulating neurophysiological processes when considered in the light of beliefs about illness and disease? Some researchers have taken this on directly by attempting to induce illness symptoms by providing misinformation in a controlled environment. By comparing two groups who inhaled an inert substance as an experiment, Lorber and colleagues successfully induced symptom complaints in one group who were informed of possible, toxic side effects from inhalation. Although the symptom list was artificial and created by the researchers, symptom

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696 Ibid., 209. The point here is not about the truth-value of the belief but about the consequence of belief. It is possible that there is a subset of the population with a predisposition to such views of self, or neural substrates for such views, that are antecedent to and facilitate the conversion to Christianity. This cannot be known from the present studies. More likely, however, is that some feature of Judeo-Christian, individualist perspectives of the self have become internalized as a consequence of the conversion to and practice of the newly embraced tradition.


reports were significantly greater for the group informed about such effects. The authors suggest that the mechanism at play in their research can account for cases of “mass psychogenic illness”. In any case, belief itself is capable of affecting neurophysiology such that bodily experiences manifest.

6.5 Concluding Thoughts

Throughout this project I have attempted to draw the reader through a long and broad array of materials and intellectual disciplines in order to accomplish a number of goals. First, I wanted to show that SJSR is alive and well in China and the world today, and it is properly understood only within the discourse of nerves that arose in a nineteenth century Euro-American context. Second, I have tried to argue that its importation into and domestication within the Chinese lexicon and social-psychological milieu took place through a process of China’s coming-of-age on the world stage. The writings of physicians, novelists, students, quacks, advertisers, and intellectuals were made available to a Chinese population at a unique time in its history, when print was available like never before. SJSR became a culturally salient category of experience with a well-established framework for what it meant to be in distress in the modern world. These first two aims prepared me to address a subject that has intrigued me for a number of years. Specifically, my third aim was to highlight the neurasthenia-depression controversy that arose out of Kleinman’s works, which were first read in the early 1980s. I have demonstrated that his arguments were based on the notions of Asian suppression and denial of affect, linguistic incapacity for emotional descriptions (poverty of language), the need to avoid stigma by using clinical categories that failed to delineate the underlying reasons for patient distress, and the illness/disease distinction. His view of SJSR in China opened up decades of inquiry and redefinition of what the Chinese experience of distress “really was”, which is ongoing to this day. My fifth chapter assessed the efforts of researchers in

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700 It is well beyond the scope of this project to demonstrate how belief and cognition both occur within conscious and unconscious processes. It is well known that Freud popularized the phenomenon of unconscious process, but contemporary neuroscience has also begun clearly to demonstrate that cognitive processes in the brain occur all the time without the need for conscious awareness. The field of neuropsychoanalysis is one place to begin considering how these processes are clinically interesting. See: Mark Solms, *The Feeling Brain: Selected Papers on Neuropsychoanalysis* (Routledge, 2018); Mark Solms and Oliver Turnbull, *Brain and the Inner World: An Introduction to the Neuroscience of Subjective Experience* (Other Press, LLC, 2010).
China and several Western countries as they considered alternative categories of diagnosis and parsed precisely what could be meant by the claim that “Chinese somatize”. Today, rates of depression are increasing in China, and the more recent revitalization of past arguments, which are employed to account for this increase, simply make the claim that Chinese have suffered from a poverty of emotional expression and suppression of affect as a result of political repression. In addition to the incoherence of these types of claims, especially when viewed in light of the broad impact of the SJSR experience on Chinese people outside of Mainland China, we see categories very similar to SJSR serving to capture the experience of many people around the world (dysautonomia, among others).

As research into SJSR continues into the future, I am certain that much more material will be uncovered that will demonstrate even more complicated and rich ways that SJSR was understood in the past and shaped the lives of those who found the concept to be an accurate description of their experience.\textsuperscript{701} I am confident such research will only further demonstrate the need to develop a more nuanced conceptualization of how culture and the experience of what we might call “psychiatric distress” interrelate. The undercurrent of this project has really been to present a model of this interrelation.

To return to the symptom pool, it is important to ask again the question about moving from descriptions of experience to embodiment. In the introduction, I mentioned that for Edward Shorter, patients “somehow conformed” to the symptom pool of hysteria and neurasthenia.\textsuperscript{702} The creation of a symptom pool is a complicated sociocultural process that I have attempted to address throughout the materials addressed in this project, especially in Chapters 2 and 3. As shifting paradigms of what it means to be ill (whatever the category) are produced in print or on screen, the larger population gains access to a symptom pool that is not confined to the specialized textbooks used by clinicians. Cultural beliefs can then be internalized by the individual. The mechanism for conformity to the symptom pool is the neurophysiological consequence of belief itself. As patients find culturally recognized and sanctioned forms for the expression of real-life distress, they manifest symptoms that are both meaningful and available.


\textsuperscript{702} Shorter, From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era.
Psychiatry and medicine are discourses that are aided by representations in a way that has only recently been considered. Rather than merely critique psychiatry as a hegemonic form (which it is), I have tried to show one way that psychiatry has such self-fulfilling power. It opens up a space for the expression of pathology; it creates niches for manifesting the distress that many people experience. Through its categories, symptom formation becomes a possibility. Ian Hacking refused to address whether the mental illness of dissociative walking fugue was real or not. It was obviously a social construction, but was it real? It was as real as hysteria, neurasthenia, depression, koro, or any other illness for which clearly defined symptoms exist. They serve as temporally, geographically, and culturally specific modes of manifesting human distress and inner perturbation, which distress is culturally formed and, through belief, can be translated from the mind to the body and vice versa.
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