SUFFERING IN STYLE

by Richard A. Shweder


Social Origins of Distress and Disease (henceforth Social Origins) is the most important book to be written in medical anthropology in a long time. The book is stimulating, passionate, sophisticated, balanced and theoretically up-to-date. It sets out an inspiring agenda for the anthropological study of suffering. It raises profound questions about psychic and physical pain, spiritual embodiment and somatization, and about the possibilities of cross-cultural understanding and translation of the subjective states of the "other." It entertains the view that forms of suffering vary across cultures and historical epochs. It advocates a holistic, dialectical, interactionist view of the interrelationships between mind-body-society-culture-nature. It advances a socio-political causal ontology of loss, defeat and social injustice for the explanation of suffering (angst and amines make room for oppression; ego isolation and neurotransmitters make room for adverse social conditions), inevitably leading the thoughtful reader to consider the range of causal ontologies or theodicies (bio-medical, moral, socio-political, interpersonal, psychological, etc.) that might get invoked, and are invoked in different regions of the world, to define the circumstances of suffering. In the context of a recent Current Anthropology treatment of Social Origins Kleinman (1986b: 508) has called on anthropologists to develop a "forceful cultural critique and a more complex anthropological alternative to the current paradigm of social epidemiology." Social Origins presents just such a cultural critique and complex alternative. Everyone should read it carefully and come to terms with its crafted complexity.

One central theme in Social Origins is the evaluation of claims on behalf of neurasthenia and depression that they be designated illness experiences and/or disease entities. Like much of the book the exegesis is brilliant and complex, a stimulating and fluctuating evaluation by a master of dialectics and interactionism, trying in the name of the virtues of holism to do the best that can be done with that now famous, ambiguous, polysemous and shaggy distinction between illness and disease. In this review essay I hope to open a critical dialogue about the usefulness of the polysemous illness/disease distinction as an analytic tool in the cross-cultural study of suffering. I have some doubts.

First, however, I shall try to formulate a summary of the key research problem and findings of *Social Origins*, relying as little as possible on the global distinction between illness/disease, although, along the way unpacking a few of its many parameters of meaning. That summary formulation should be read as an exercise in interpretation; it is my way of telling the story about the relationship of neurasthenia and depression as I see it revealed by Kleinman's agenda-setting research in China. There will be some digressions for commentary.

In Kleinman's telling of the story, told in the language of illness and disease, neurasthenia, when viewed as an illness experience, is interpreted as somatized depression, and depression, viewed as a disease entity, is identified as its underlying disease. Depression, viewed as an illness experience, is interpreted as a less disguised or less transformed or perhaps more psychologized version of the same underlying disease, depression, again viewed as a disease entity (1986: 1, 66, 165). What precisely depression is as a disease entity (that is, as distinct from an illness experience) is intimated but not fully told in the story, although it is linked, in the reconstruction of life histories and in theory, to demoralizing and psychically painful social conditions — job dissatisfaction, school failure, financial difficulties and other defeats and losses on various micro socio-political fronts, associated, in this instance, with macro socio-political upheavals in China (e.g., the "cultural revolution").

Kleinman forthrightly invites a healthy scepticism from his readers and magnificently designs his book, which is so sensitive to the hazards of cross-cultural "translation," so as to stimulate and encourage debate about his theoretical models. Stimulated and encouraged in that way I am going to try to tell the story of *Social Origins* with a slightly different punch line.

In my telling of the story I am going to distinguish forms of suffering (for example, the experience of neurasthenia or depression) from the causal ontologies or theodicies that are invoked to explain them (for example, a bio-medical ontology of organ pathology/physiological impairment/hormone imbalance, or a moral ontology of transgression/sin/karma, or a socio-political ontology of oppression/injustice/loss, or an interpersonal ontology of envy/hatred/sorcery, or a psychological ontology of anger/desire/intrapsychic conflict and defense, etc.).

Suffering, as I will use the term, signifies the experience of disvalued and unwanted subjective states (feelings, sensations, emotions, ideas); its meaning overlaps aspects of the concept of "illness" as defined by Eisenberg (1977: 11) and Kleinman (1986: 225): viz., the experience "of disvalued changes in states of being and in social function," "the way individuals . . . perceive symptoms, categorize and label those symptoms,
experience them, and articulate that illness experience through idioms of distress and pathways of help seeking." Suffering takes on form when it becomes organized and meaningful and is experienced and expressed as suffering of a certain kind, for example, as depression or as neurasthenia.

In contrast, a causal ontology (or theodicy), as I will use the expression, signifies the events and processes going on in some other order of reality (bio-medical, moral, socio-political, interpersonal, psychological) that are thought to generate or cause the experience of suffering. The notion of a causal ontology or theodicy converges in meaning with one special sense of the concept of "disease" as used by Kleinman (1986: 146—147), the interpretation of a sufferer's problem as a specific abnormality in some nosological system, without prejudice as to the type of nosological system (bio-medical, astrological, moral, etc.) used in the interpretation.

For reasons I shall enumerate later I prefer the distinction between "forms of suffering" and "the causal ontologies (or theodicies) invoked to explain them" to the distinction between "illness" and "disease" (which presupposes, and hence privileges, a bio-medical view of the world and its bio-medical discourse, in the very act of seeking a supplement to bio-medicine and revaluing its residues). But first I want to formulate a summary of the key research problem and findings in Social Origins, using only the first set of terms.

The research problem can be stated as follows: There is a form of suffering called "depression" and there is a form of suffering called "neurasthenia." It appears that neurasthenia, but not depression, is a popular form of suffering in China, and that neurasthenia, but not depression, is a popular diagnosis of suffering by Chinese psychiatrists. It also appears that depression, but not neurasthenia, is a popular form of suffering in the United States and Europe, and that depression, but not neurasthenia, is a popular diagnosis of suffering by Western psychiatrists. Finally, it seems that one hundred years ago neurasthenia was a popular form of suffering in the United States and Europe, but in our recent history it has gone out of style and is no longer even listed as a form of suffering in the American Psychiatric Association's standardized manual for diagnosis of psychopathology (DSM-III).

Kleinman goes to China in 1980. His field site is the psychiatric outpatient clinic at the Second Affiliated Hospital of the Hunan Medical College (formerly known as the Yale-in-China Medical College). He selects one hundred patients suffering neurasthenia, according to Chinese psychiatrists. He diagnoses most of them (87) as suffering depression, after a clinical interview and assessment, using the DSM-III manual (which, remember, has no diagnostic category for neurasthenia). Follow-
up interviews are conducted with seventy-six of the patients and second follow ups with twenty-three. Three years later Joan and Arthur Kleinman collect detailed case histories from twenty-one of the original patients; thirteen of those case studies are presented in the book. Although emotional and psychological disturbances are either not salient in the minds of these Chinese patients or are not discussed readily in their reporting of complaints (1986: 75, 81), careful scrutiny and sensitive questioning uncover the following kinds of subjective states in a prototypical case (e.g., 1986: 107, 109): headache, low self-esteem, fatigue, sadness, dizziness, feelings of hopelessness, insomnia, anxiety. The Chinese call that neurasthenia; the DSM-III and Kleinman call it depression.

The finding is suggestive. It raises the question: could it be that, whatever the label and whoever the diagnostician, neurasthenia and depression are really the same form of suffering, in China and in the West, a century ago and today?

Social Origins establishes that the answer to that question ought to be "no"! Neurasthenia and depression are distinct forms of suffering whose popularity waxes and wanes across cultures and across history (even though, as Kleinman hypothesizes, they may have a common socio-political causal ontology — engendered by defeats and losses of one kind or another — and may be responsive to the ingestion of similar substances). The original finding, that patients in a Chinese psychiatric clinic who are diagnosed by the Chinese as suffering neurasthenia would be diagnosed using the DSM-III as suffering depression, turns out to be a red-herring, as we shall see.

Are neurasthenia and depression different labels for the same form of suffering, or are they different forms of suffering? And how does one go about answering such a question? There are a variety of parameters in terms of which one can assess the sameness or difference of two forms of suffering. Social Origins is an outstanding book, in part, because it explores or speculates about almost every one of them.

One can ask, are they the same or different with respect to their significance, their denotation, their connotation, their practical consequences, their causal ontologies and their responsiveness to therapeutic interventions of various kinds. As I read and interpret Social Origins, Kleinman's research establishes that neurasthenia and depression are quite distinguishable and separate forms of suffering.

For one thing, neurasthenia and depression signify different things. By "signify" I mean the ideas, notions, concepts or properties implied by a term or expression. Neurasthenia signifies a form of suffering experienced
as brain fatigue or frayed nerves or worn out fibers or depleted juices, the run down feeling of overloaded and straining CNS circuitry or of sluggish blood, a form of suffering experienced as and expressed by the sufferer as an affliction of the central biological operating systems of the body. Depression, in contrast, signifies a form of suffering experienced as demoralization and hopelessness, the resignation and loss of animus of a dispirited ego, a form of suffering experienced as and expressed by the sufferer as an affliction of the central goal striving systems of the soul or ego.

Second, neurasthenia and depression denote different things. By “denote” I mean the events, states and objects selected out and pointed to by virtue of what is signified by a term or expression. Neurasthenia denotes a set of subjective states, primarily headaches, dizziness, insomnia, tiredness, weakness and muscle tension, interpreted as intrinsic or inherent aspects of the experience of central nervous system fatigue, or precious bodily fluid (blood or semen) depletion. Depression denotes a set of subjective states, primarily sadness, hopelessness, self-deprecation and anxiety, interpreted as direct expressions of the anguish of a demoralized soul or ego.

Third, neurasthenia and depression have different connotations. By “connotation” I mean the non-criterial attributes, extrinsic aspects and secondary associations that sometimes accompany a form of suffering, but are connected to it only as a derivative concomitant. For example, the concept “surgeon” does not signify the feature “male” nor does it denote a set of objects that are “male”; the set of objects it denotes are picked out and selected for membership in the set without regard for their “maleness.” Surgeon, however, does connote “maleness,” at least to Americans, because, in America, most objects picked out for membership in the set of objects denoted by surgeon happen contingently to be male. Yet from the point of view of the significance and denotation of the concept “surgeon,” its association with “male” is incidental and extrinsic, a happenstance.

Neurasthenia and depression have different connotations. The connotation of neurasthenia is a set of extrinsic or incidental subjective states which may or may not accompany it, as secondary psychological derivatives. That connotative set includes feelings of sadness, hopelessness, anxiety and resignation. They are the kind of feelings — psyche responding to soma — that some people experience after they become convinced that their central nervous system has become depleted of energy or that their blood is drying up. Depression also has its connotation, a set of subjective states that may or may not accompany it, yet are understandable as secondary “vegetative” derivatives: the loss of appetite that may
accompany sadness, the fatigue that may accompany the loss of hope, the headaches that express a lowering in self-esteem — soma responding to psyche. In the former case we have a psychologized derivative of neurasthenic suffering. In the latter case we have a somatized derivative of depressive suffering. Indeed, from the limited perspective of an elicited "symptom" list, the two forms of suffering (neurasthenia plus its psychological derivatives and depression plus its somatic derivatives) may be diagnostically difficult to tell apart.

As should now be apparent, neurasthenia and depression, as forms of suffering, bear the following fascinating relationship to each other: the denotation of the one is a connotation for the other, and vice versa. The denotation of neurasthenia (headaches, fatigue) is the connotation for depression; the denotation of depression (sadness, resignation) is a connotation for neurasthenia. Yet the two sets of denotata (or alternatively put, the two sets of connotata) need not, and often they do not, occur together in patients.

The finding from the psychiatric clinic at the Hunan Medical College was a red herring. It just so happened that in that patient population the two sets of denotata happened to co-occur. When that occurs a mere "symptom" list is ambiguous and diagnosis with the DSM-III (which encodes the concept of depression but not the concept of neurasthenia) can be hazardous; for one may be led to misclassify neurasthenia as depression, or worse yet to conclude that neurasthenia is depression.

Fortunately, as Kleinman discovered, the two sets of denotata do not always co-occur. There are large numbers of people around the world who suffer neurasthenia unambiguously and without the optional connotations that might be (mis)construed as the denotations of depression. In the Taiwanese primary care unit also investigated by Kleinman, 57% of patients suffering neurasthenia did not meet the DSM-III criteria for depression (1986: 102, 204). Kleinman's data here converge with evidence from an Indian psychiatric out-patient clinic (Jindal, Rastogi and Rana: 1978), where only 20 out of 61 patients suffering from neurasthenia displayed "symptoms" that might be (mis)construed as the denotata of depression.

Similarly the dysphoric subjective states denotative of depression (sadness, hopelessness, low self-esteem, loss of interest in the world, anxiety) need not be associated with the subjective states denotative of CNS fatigue (headaches, dizziness, weakness). There are people who experience depression free of those somatic derivatives that might be (mis)construed as the denotata of neurasthenia, although it does appear that many people who experience depression without somatic derivatives experience it in
association with secondary psychological derivatives instead, for example, indecision, guilt, fantasies of death, etc.

The rub is that in those cases where the denotative and connotative features are both present, a mere listing of "symptoms" will not help you distinguish neurasthenic suffering from depressive suffering; and if you make a diagnosis using an inappropriate or wrong "theory" about what is denotative and what is connotative (i.e., your prior notion of the significance of the suffering, or an institutionalized canon of significances such as the DSM-III) you may be led to misclassify neurasthenia as depression, or vice versa.

Fourth, neurasthenia and depression also have different pragmatic consequences. Because of the different things neurasthenia and depression signify and denote as forms of suffering they are appraised differently in the context of Chinese and American social institutions and cultural values. Depressed, demoralized and hopeless souls are in China stigmatized and tarred with the label of political disengagement (1986: 94). Depression is the wrong form of suffering for China, a genre too embarrassingly personal for public display (1986: 154). It is more suitable for the values and tastes of the American white middle-class where, as Kleinman puts it so eloquently, it expresses "the heroic romance of the lonely individual testing his existential condition by being obdurately solitary, the equity of each independent person naked before his just god . . . , the narcissistic conception of man's ultimate, ego-centric rights, the bitter disillusionment with sentimentality at not 'making it' in the marketplace" (1986: 178—179). CNS fatigue, however, was the right form of suffering for China in 1980 and perhaps also in 19th century Europe and the United States. Suggestive of having become physically run down or depleted by the pressures and hard works of life it was an acceptable rationalization for failure and a locally rational and legitimate excuse for time off from work and for requesting a change in jobs.

While neurasthenia and depression are distinct and separable as forms of suffering, it is argued in *Social Origins* that they share a common socio-political causal ontology, engendered by defeat, loss, vexation and oppression within local power hierarchies (1986: 79, 167—168, 174, 181).

*Social Origins* describes in socio-political terms the humiliations and frustrations (job loss, school failure, financial difficulties, family problems, marital struggles, etc.) of the neurasthenic sufferers, many of them victims of the so-called cultural revolution and anti-right campaigns in China. Deeply pathetic life experiences are narrated without pathos, yet with great sympathy and power. "Some experienced such overwhelmingly
destructive personal tragedies that they developed major personality changes: a few became so deeply embittered that every aspect of their lives radiated anger and hatred and alienation; others withdrew with fear and hurt into the inner privacy of the isolated self, diminishing performance to match greatly reduced expectations, to protect against further losses. Yet others organized their lives around their repeated and multiple losses as prolonged or even continuous grief reactions" (1986: 170—171).

Kleinman hypothesizes a universal socio-political causal ontology as a world-wide explanation of neurasthenic and depressive suffering (1986: 79, 167—168). This is a bit surprising, for Kleinman is very sensitive to the dangers of overgeneralization from one or two culture areas and from a limited data base, and he is well aware that, when it comes to forms of suffering like neurasthenia and depression, a person's representations or descriptions of the nature of her suffering and its causes can be part of the suffering it describes. He quotes Nelson Goodman approvingly to the effect that reality is not independent of our version of it, and “there are many worlds if any” (1986: 143, 165). (Also see Kleinman 1986: 56 on alternative cultural conceptions of the causes of suffering.)

So the reader feels slightly bewildered by the postulation of a universal causal process, and several questions come to mind. Why should socio-political forces and events cause neurasthenia and depression independent of our representation of those forces and events? Is it not our representation of socio-political forces and events that defines the terms of our involvement with those forces and events, and our reactions to them? Perhaps what is meant by the claim of universal causation is that on a world-wide scale socio-political forces and adverse social conditions are represented in a similar way, a universal pattern of construal leading to the experience of either CNS fatigue or demoralization. Yet why should representations of the causal ontologies for neurasthenia and depression be any more universal than are representations of the experience of neurasthenia and depressions its significance, denotation, connotation or practical consequence?

Murdock (1980) did a cross-cultural survey of explanations for illness, which suggests that preferred causal ontologies for suffering are unequally distributed around the world and cluster in geographical regions. A reasonable, even if sceptical response to Social Origins is that the socio-political causal ontology (defeat, injustice, loss, and oppression) preferred by the Chinese (and by some other cultures) as an explanation for their suffering may play an important part in making them sick and in their meaningful reconstruction and representation of their life history, yet it remains to be seen whether it is a universal or even privileged cause of neurasthenia and depression.
After reading *Social Origins* and the socio-political causal discourse of Chinese patients I turned to my files of interviews, texts and field records (including discourse during healing sessions) from research with traditional Hindus in Orissa, India. I retrieved, using a computerized indexing system, all materials in which mention was made of illness, sickness or suffering. In that South Asian corpus socio-political causal explanations for suffering (references to oppression, injustice, adverse social circumstances or even references to stress, pressure and strain) were rare, although loss (e.g., the death of a child) was certainly mentioned as a proximate cause of suffering.

Several alternative causal ontologies were prevalent in the South Asian corpus. The most common was a moral causal ontology, notable for its references to transgression, sin, divine retribution, sacrifice, austerity, sanctity and karma, associated with the notion that a loss of moral fiber is a prelude to disaster and physical suffering, which is its natural outcome and just desert. “What sinful work have I done that now I am suffering [without a child, with leprosy, as a widow]?” “What mistake have I made that the goddess is bothering me?” Life histories are sometimes narrated in those terms.

But many other causal ontologies were invoked as well. There was an interpersonal causal ontology, notable for its references to sorcery, black magic, evil eye, bewitchment and spirit attack, and associated with the notion that one can be made sick by the envy and hatred and ill-will of people who want you to die, suffer or fail (on spirit attack as a cause of suffering see Nuckolls: 1986).

There was a bio-medical causal ontology, notable for its references to hot and cold foods, and associated with the notion of humors and substances that affect the brain and the notion of precious bodily fluids (blood and semen) that enhance physical well-being. [Indeed, in the South Asian context one can imagine excessive masturbation as a plausible cause of neurasthenia and/or depression. The masturbator, conscious of his uncontrolled and “sinful” depletion of what he thinks of as an essential life force, feels weakened and guilty, and demoralized by his inability to exercise authority over his body; see Kelly 1987 on *dhat* “syndrome” in India; also Kleinman 1986: 76—77 on *shen kui* “syndrome” in Chinese communities].

There was also a psychological causal ontology, associated with the notion that unfulfilled desires (e.g., never getting married and missing the experience of a family life) can make you sick. And an astro-physical causal ontology, notable for its references to horoscopes and malevolent planets and inauspicious periods of time. One case of suffering most relevant to neurasthenia and depression (the healer described the client’s
condition as sluggishness, biliousness, feelings of sorrow, fickle-mindedness, indecisiveness, forgetfulness, accompanied by chills and sleeplessness) was explained by reference to arrangements of the stars, which come and go.

One looks forward to much future research in medical anthropology addressed to the question of whether across the various cultures or cultural regions of the world, a socio-political causal ontology gives a better account of neurasthenia and/or depression, or provides a more powerful means for the meaningful reconstruction and representation of a life of suffering, than does any of those other causal ontologies. It seems not unreasonable to postulate that a people's causal ontology for suffering plays a part in causing the suffering it explains, just as a people's representation of a form of suffering may be part of the suffering it represents.

Those last remarks speak to an unresolved and perhaps unresolvable tension in Social Origins. Kleinman seeks a golden mean between a constructivist (or interpretivist) view of realities, understood in terms of what some philosophers would call "intentional" categories, and a transcendent conception of a "broader reality" that everyone ought to accept in the name of a universal science of so-called "natural" kinds (1986: 67, 143–144, 165). According to some philosophers, science seeks to discover "natural" kinds, which are classes of events that exhibit a causation independent of what they mean to us, independent of our involvement with them, independent of our experience of them or evaluation of them, independent of our aesthetic or emotional response to them. Constructivists (or interpretivists), in contrast, seek to discover "intentional" categories, which are classes of events that exhibit whatever causation they may have by virtue of what they mean to us, by virtue of our conceptions and representations of them and reactions to them. Black holes and hydrogen are natural kinds. Windsor chairs and punk hairdos are intentional categories.

There is a complex tension in Social Origins between constructivism and science, between intentional categories and natural kinds. At times Kleinman speaks approvingly of the constructivist position of Nelson Goodman that "there are many right world-versions, some of them irreconcilable with others . . . ," world-versions whose multiplicity cannot be reduced by empirical evidence (1986: 143, 165). At other times he speaks of those same purportedly irreconcilable world-versions as the "iron cage of incomparable localism," suggesting that they are really merely alternative idiomatic versions of some broader reality that a universal science should be able ultimately to describe (1986: 67, 144, 165).
Kleinman's holistic, dialectical interactionism leads him to look in both directions and to try to have it both ways. He proposes to reduce the tension between the idea of irreconcilable culture-specific world-versions and the idea of a broader or universal natural world by interpreting forms of suffering such as neurasthenia and depression in a constructivist discourse of intentional kinds (what he calls "illness experiences," which are responsive to social evaluation, and hence may be culture-specific) while interpreting their causation in a scientific discourse of natural kinds (what he calls universal "diseases"). It remains to be seen whether this is a golden mean (a creative tension) between constructivism and science or whether, as some critics will be bound to suggest, it is a middle path between right and wrong.

As I interpret it, it is the resounding, and utterly persuasive, constructivist message of Social Origins that somewhere in-between a literal lesion and a literary trope there is a lot of room for a broken heart. What that means is that frayed nerves, tired blood, splitting heads and broken hearts can be thought of as the metonymic metaphors of suffering; they give poetic expression by means of body-part metaphors to forms of embodied suffering experienced through the body-parts used to express them. (That poetic suffering is sometimes redescribed in the discourse of bio-medicine as "somatization").

Of course, splitting heads do not split, broken hearts do not break, tired blood continues to circulate at the same rate, and frayed nerves show no structural pathology. Yet metonymic metaphors using body-parts to express suffering are a good example of the kind of "symbolic reticulum" (a favored expression in the book) that Kleinman investigates and promotes. That symbolic reticulum provides a bridge across the gap between the unseen and unseeable subjective world of our feelings, sensations, emotions and thoughts (our states of mind) and the seeable, directly manipulable world of concrete objects, in this case the inanimate juices, fibers and organs of our body made soulful through suffering as well as mindful of a fall from grace. (On body-part metaphor see Haviland n.d.; on states of mind experienced and expressed through the body see Shweder 1987).

That "symbolic reticulum" stretches across a vast sea of suffering, sometimes described by biomedical healers, for lack of an adequate comprehension, as a "functional" disorder of the [name the relevant body-part] with no apparent organic pathology, no apparent structural deficit and no apparent physiological impairment outside the normal range.
One might describe that sea of suffering as "illness without disease" (Eisenberg 1977), an oxymoron, if formulated within the reductionist monistic discourse of biomedicine. The head is splitting but the CAT scan is normal and there is no brain tumor. The chest is caving in but the treadmill test looks fine. Must something be biomedically wrong? Or do we just throw up our hands and say "tension headache", next patient please."

The suffering of the (apparently) biomedically fit is our contemporary version of the classic problem of Job — the suffering of the (apparently) righteous. Such suffering — of the righteous or the bio-medically fit — is an insult to our ontological sensibilities and raises deep questions about the types of causal forces that might be out there causing it.

The classical problem of Job can be resolved by postulating that Job must have sinned (if not in this life then in a previous one) and that the suffering of the righteous is merely apparent. Similarly, the contemporary problem of Job can be resolved by sticking to a single causal ontology, postulating that all suffering is bio-chemical and that if you suffer you must not be bio-medically fit, we must have not yet discovered the problem.

*Social Origins* demurs from any such single-minded reductionist monism and from those types of dualism that permit no interaction between mind and body. The book elaborates an interactionist position, arguing that there is a great deal more to the causation of physical and psychic suffering than bio-medicine can comprehend, and much "transduction" from adverse social conditions into psychic pain and from psychic pain into the experience of physical suffering.

Kleinman (1986: 39, 162—163) actually denounces dualism in general, and states that it is "scientifically untenable." As I read his objections, however, they are really aimed at a much narrower and extreme view, a view certainly not held by Descartes, who is sometimes parodied in these terms, that mind and body are separate, unconnected, autonomous domains, each acting totally independently from the other. Dualism is not reducible to that view and Kleinman’s interactionism, as far as I can judge, is a type of dualism. Karl Popper, a dualist and an interactionist, thinks interactionism is the philosophy of mind and nature promoted by common sense; it distinguishes the mental from the physical yet acknowledges that, for example, intending or willing to do something can cause a physical movement, and that a physical cut can cause the subjective experience of pain.

As I understand it the issue at stake in the mind/body controversy is not whether common sensical folk, or scientists, report that such things happen. The issue is whether such things happen in the way they are
represented by common sense or by some scientific observers — thoughts and things represented as distinguishable ontological realms influencing one another. The problem is to make theoretically credible such a possibility (how precisely, and by what means, does “transduction” take place between thoughts and things?) or, alternatively, to explain the possibility away — by representing thoughts as things (monistic materialism) or things as thoughts (monistic idealism), without replacing one perplexing problem with another. It is not at all clear to me how science can resolve the differences between monists and dualists or between different types of monists or different types of dualists, since the differences in all cases are metaphysical differences over how to represent the facts. In another context (1986: 165) Kleinman formulates a brilliant statement to the effect that the “conceptual framework” within which research is organized is beyond assessment by scientific findings. I do not see why conceptual frameworks for talking about mind and body should be exceptions to that formulation.

Finally, it is noted in Social Origins that, as forms of suffering, neurasthenia and depression are responsive to the same class of ingested substances (1986: 91—92, 164—165). Kleinman mentions some of the difficulties involved in interpreting that point of similarity between neurasthenia and depression. American psychiatrists interpret the ingested substances as “antidepressant drugs.” A few Chinese psychiatrists interpret the ingested substances as “antineurasthenic drugs.” Yet both interpretations are gratuitous, for the causal ontology is poorly understood that links the ingested substances to “symptom” relief. [As I understand it, one of the persisting anomalies from biochemical research on the experience of depression is that the postulated biochemical disturbances — of enzymes involved in catecholamine synthesis or norepinephrine in CNS pathways — typically turn out to be of low magnitude, and more importantly, unlike classic metabolic pathologies, the biochemical levels of the sufferer are typically within the statistical range of the biochemical levels for normals in the population].

I suppose one could go further, arguing that “symptom” relief via ingested substances per se does not even establish the type of causal ontology (bio-medical, moral, interpersonal, etc.) relevant for explaining the suffering. Certainly in many parts of the world where spirit attack is a preferred explanation for suffering there is an expectation that possessing spirits do not like substances of certain kinds (e.g., mustard seeds), which are ingested therapeutically to drive the spirit out. It is also conceivable that today’s efficacious ingested substance of contemporary science might turn out to be a kind of broad-spectrum anesthesia (or “opium of the
people") for psychic, spiritual and physical pain, and thus neutral as to causal ontology.

To this point of my review, I have presented an interpretive summary (with commentary) of the central points of *Social Origins*, relying as little as possible on the notions of illness and disease. Without those notions the story told in *Social Origins* is stimulating, powerful and easy to comprehend and it goes like this: neurasthenia and depression are distinct forms of suffering (the first popular in China, the second in contemporary Europe and the United States), both precipitated by the same cause — adverse social conditions, oppression, defeat, loss and humiliation. The differential popularity in China and the contemporary West of the two forms of suffering is understandable in the light of various cultural and institutional differences between the two societies, and here they are . . .

Yet Kleinman wants to say more (1986: 1, 66, 165). He wants to say that depression is not only a form of suffering (an illness experience), it is also a universal disease. And he wants to say that neurasthenia (as an illness experience) is really a somatized variety of depression, the underlying disease. It is right there in the argument, with the designation of depression as a disease (apart from an illness experience) and neurasthenia as somatized depression, that I get confused and a bit nervous. And what I think makes me confused and nervous is that shaggy distinction between illness and disease.

The distinction between illness and disease is described in a marvelous and uplifting essay by Eisenberg (1977: 11). Everything about the essay is wonderful, except the specifications for the distinction between illness and disease. Let us consider and worry a bit about some of its multifarious and shifting meanings.

An initial specification presented in the essay is that “. . . patients suffer ‘illnesses’; physicians diagnose and treat ‘diseases.’” This implies one or the other or both of two things. First that the difference between illness and disease is a difference in perspective (patient vs. physician; also described as lay vs. professional); second, that the difference between illness and disease is a difference in mode of activity (suffering vs. diagnosis and treatment). It is unclear, from the specification, however, what to say of a sufferer who diagnoses and treats himself. Has he diagnosed and treated an illness or a disease? Does the answer depend on whether the sufferer diagnosing and treating himself is a layman or a professional?

To complicate things further there is much uncertainty about what the difference in perspective (patient vs. physician, or lay vs. professional) is supposed to amount to. Is it the difference between a novice perspective
vs. expert perspective? A local folk perspective (perhaps by an expert) vs. a universal scientific perspective (perhaps by a novice)? A non-biomedical perspective vs. a biomedical perspective? An incorrect biomedical perspective vs. a correct biomedical perspective? A perspective that views any system in its interactions with other systems vs. a perspective that analyzes each separated system in its own terms? A perspective inclusive of the generalized concerns of a sufferer vs. a perspective narrowly focused on the causal and treatment concerns of the diagnostician? Does it matter whether the diagnostician adopts the causal ontology of contemporary biomedicine? What if the diagnosis is "semen loss" or "spirit possession" or "divine retribution" or "demoralizing social conditions"? Are those "diseases", according to the definition?

Eisenberg elaborates the definition as follows: "illnesses are experiences of disvalued changes in states of being and in social function; diseases, in the scientific paradigm of modern medicine, are abnormalities in the structure and function of body organs and systems."

What is left pregnantly ambiguous in that definition, of course, is whether the disease concept is to be defined by the biomedical causal ontology of modern medicine, or whether the biomedical causal ontology of modern medicine is merely being used as an optional illustration of the disease concept. Could the definition just as well have read: diseases, in the scientific paradigm of modern Ayurvedic medicine, are somatic imbalances of the ratios of wind, water, fire, earth and ether? Or perhaps, diseases, in the scientific paradigm of modern astrology, are malevolent configurations of planets, stars and moons? Or are those not disease categories because they do not correspond to the causal categories of modern Western medicine? Or are they to be treated as disease categories, but false or fictive ones?

The illness/disease distinction, because it is pregnant with meaning, has undoubtedly served an important purpose in alerting biomedical professionals that there is a great deal more to suffering than biomedicine can comprehend and in defining a broad and promising research agenda for medical anthropology and for a social and holistic medicine (for spectacular statements in that regard see Eisenberg 1977 and Kleinman 1986c). Yet it is precisely because the illness/disease distinction is so pregnant with meaning that I have some doubts about its analytic usefulness. Its interacting meanings are too volatile to control and just fickle enough to be exasperating.

This is how Kleinman's subtle and stimulating analysis of the cultural construction of suffering gets told in the ambiguous and polysemous (and exasperating) language of illness and disease. In some contexts (1986: 66,
neurasthenia is judged to be an illness experience but not a disease (depression is judged to be the underlying disease process), and depression is judged to be both an illness experience and a disease process. In such contexts, when neurasthenia is judged to be an illness experience but not a real disease we are encouraged to view it (from the perspective of universal science) as somatized depression.

Here I get a little confused. If a disease process is different from an illness experience and if depression is a disease process (as well as an illness experience), then what precisely is that depressive disease process that is other than an illness experience, and how do we know that neurasthenia is a somatized version of it? Is the depressive disease process that is said to underlie the illness experience of both neurasthenia and depression a socio-political "disease" process; that is, is the "disease" the demoralizing social circumstances that are a major focus of the book? That is, is the concept of disease being used here in a non-biomedical sense? Or is the underlying depressive disease a biomedical disease process (1986: 1, 58, 66)?

Depressive disease is described at least twice in Social Origins as a "psychobiological template" for a "universal core depressive disorder" (1986: 66) and as "characterized by psychobiological dysfunctions which appear to be universal" (1986: 1); and, at least once, that psychobiological template is described as "the outcome of the interaction between personal vulnerability (psychological-physiological state), major stressful life events, coping processes and the social support... [within local contexts of power] that influence how risk, stress, and resources are configured and systematically interrelate" (1986: 168). Yet those expressions and formulations are not really helpful in comprehending depression as a disease (vs. illness experience); for the idea of a psychobiological dysfunction seems designed to be ambiguous with repect to the concept of illness and the concept of disease, and we are left wondering just what it is that is disordered and is psychobiological and is other than neurasthenia or depression as illness experiences, which, as illness experiences, are two culture-specific forms of suffering.

One possible interpretation of the argument, staying within the language of illness and disease, is that adverse socio-political circumstances cause "psychic pain," which is experienced and expressed either in the ("disguised") idiom of physical pain (neurasthenic illness) or in the ("direct") idiom of psychic pain (depressive illness).

By that interpretation depressive disease denotes a hypothesized moderator variable called "psychic pain." That hypothesized moderator variable makes it possible for an outside comparative analyst to think of
neurasthenia and depression (the illness experiences) as alternative and distinct ways of experiencing the same thing, the hypothesized "psychic pain."

Yet if we follow that line of reasoning we end up with a rather Platonic moderator variable, and it is a rather psychologized Platonic variable at that: an abstract pain that exists prior to or independent of its qualitative experience as either neurasthenia or depression, yet is the common cause of both. Still, whatever one thinks of Platonic moderator variables, why should we call "psychic pain" a disease rather than an illness? Is any type of imagined or constructed cause to be referred to as a "disease"? Shouldn't the discourse of biomedicine be kept where it belongs and works so well — with infections, and organ pathologies and physiological impairments, etc.

Yet still another difficulty remains, if we keep talking in the language of illness and disease. If both the neurasthenia and depressive illness experiences are to be explained by means of the same underlying "disease" process, why should the depressive illness experience be treated as the more fundamental or privileged? Why should the neurasthenic illness experience be interpreted as somatized depression, treating depression as the disease underlying both illnesses? Why not interpret the experience of depressive illness as emotionalized neurasthenia, treating neurasthenia as the disease underlying both illnesses?

Even more deeply, why should the language for any illness experience (a form of suffering) be used to describe an "underlying" disease process or entity? Whether one defines "disease" narrowly, from the perspective of contemporary Western bio-medicine, or broadly, as the nosological categories of any kind of healer, diseases are by definition (or is it by mythopoetic conception?) postulated events taking place in a separate order of reality (biomedical, moral, socio-political, psychological, etc.) of a different logical type from the illness experience they are meant to explain. If there are "diseases" (whether biomedical, moral, socio-political, or what have you) that explain the experience of neurasthenic or depressive suffering, why shouldn't they be described in the "natural kind" language of disease instead of in the "intentional" language of illness?

In other contexts (e.g., 1986: 94—95, 165—166) neurasthenia is judged to be an illness experience and a disease process, although not for the same reasons that depression is judged to be an illness experience and a disease process. In most of those contexts, neurasthenia is judged a disease because the Chinese (and the World Health Organization) have a biomedical causal ontology for explaining the neurasthenic illness experience (1986: 152, 160, 166). Whether their biomedical explanation is correct or
not is treated as beside the point; it is argued that neurasthenia should be retained as a disease category even if Chinese professionals are wrong and it has no bio-medical foundation.

Depression, in contrast, is judged a disease not only because American psychiatry happens to have postulated a biomedical causal ontology for explaining the depressive illness experience or because Kleinman believes there is a socio-political causal ontology (mediated by abstract psychic pain) for explaining it. In judging depression (but not neurasthenia) a disease, Kleinman speaks from the perspective of the detached scientist, and it becomes relevant in evaluating the disease designation to decide whether depression really is a disease truly accountable by means of the proposed causal ontologies.

Kleinman, who is a veritable master of the illness/disease distinction, is well aware of all these difficulties. He makes explicit mention of many of them, generating many questions, promising few definitive answers, inviting a healthy scepticism from his readers; and none of my stated concerns about the analytic cumbersomeness of the distinction and its elusive (and exasperating) shifts in aspect and perspective detract from the stimulation and sheer intellectual pleasure that results from trying to stay with him through his virtuoso exercise. It is hardly his fault that the bio-medical discourse of our culture (e.g., the disease concept) is so ill-suited for representing and comprehending some major forms of suffering.

Kleinman, on the other hand, comprehends those forms of suffering very well, and his arguments seem to me most convincing disencumbered of the bio-medical rhetoric of illness and disease (for example, as I tried to interpret those arguments earlier). Neurasthenia and depression are distinct forms of suffering, which, as intentional categories, can be compared to each other because the denotation of the one is the connotation of the other, and vice versa. They go in and out of style in different cultures and at different times for reasons that cultural anthropology is well suited to illuminate. Perhaps they have a common cause in adverse socio-political circumstances, a hypothesis that social medicine is well-suited to investigate on a world-wide scale. As far as I can judge, except for grammatical requirements internal to the bio-medical language of illness and disease, there is no necessity for Kleinman to construct neurasthenia as somatized depression or for Social Origins to speak about social causation in the rhetoric of disease.

The publication of Social Origins is a major event. If we keep faith with the spirit of the book it will alert us to the way psychiatric disease concepts are used to constitute the reality they describe (1986: 165) and it will occasion a deep reconsideration of the telos in our contemporary
culture of a medical anthropology and social psychiatry. In this review essay I have tried, in my own way, to honor *Social Origins* (and its esteemed author) with a critical interpretive reading of some of the book's central arguments. It is precisely because those arguments are so profound and important that they deserve close and critical engagement. *Crescat scientia, vita excolatur.\*  

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