CHAPTER 18

Health Care Issues among Asian Americans

Implications of Somatization

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INTRODUCTION

Asian Americans (including Pacific Islander Americans) represent a significant part of the population. They are, in terms of percentage increase, the fastest growing ethnic group in the United States. In 1980, the population of Asian Americans exceeded 3.7 million, easily doubling the 1.5 million figure in 1970 (U. S. Bureau of the Census, 1988). The 1990 population of Asian Americans is about 7.3 million, nearly double that of 1980. Projections are that by the year 2020, the population will be 20 million (Ong & Hee, 1993). The Asian-American population is not only the fastest growing but also the most diverse ethnic group in terms of cultural backgrounds, countries of origin, and circumstances for coming to the United States. For example, the broad Asian-American category includes more than 50 different subgroups, which may primarily speak one of more than 30 different languages. The three largest subgroups in the Asian-American category are Chinese, Japanese, and Filipinos; significant numbers of Asian Indians, Koreans, Southeast Asians (e.g., Viet-

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namese, Cambodians, Laotians, and Hmong), and Pacific Islanders are also included in the Asian-American category.

Although research on the health status of Asian Americans has not been well developed, Asian Americans have been found to exhibit differences from other groups in terms of health status. For example, mortality rates for Asian-American adults (age-adjusted rates) and infants are lower than those of other ethnic groups including whites (Gardner, 1994). The incidence of all types of cancers combined are lower among Chinese, Japanese, and Filipinos than among whites, although higher rates have been found for certain anatomical sites such as the liver (Jenkins & Kagawa-Singer, 1994). The prevalence of chronic carriers of Hepatitis B is 8% to 15% among Asian Americans, while the prevalence is only a fraction of 1% for the U.S. population as a whole (H. Hann, 1994). Many differences exist among the various Asian-American groups. For example, obesity is much higher among Samoans and Hawaiians than among other Asian-American groups (R. Hann, 1994), and refugees from Southeast Asia have high-prevalence rates for tuberculosis compared to other Americans.

Although some of the findings on health status can be criticized because of methodological and conceptual weaknesses that often plague Asian-American research (e.g., inability to obtain large and representative numbers of respondents, cultural biases in assessment), ethnic differences on health status are not surprising. In fact, we expect the genetic–biological, cultural, dietary, environmental, and behavioral variations found among distinct racial, ethnic, or social groups to be reflected in health-status indicators. Indeed, the most interesting and significant questions are, What accounts for health status differences among ethnic groups? And how can our understanding of ethnic differences assist in the development of research, theory, and intervention (prevention and treatment) strategies that promote human welfare?

In this chapter, we discuss somatization among Asian-Americans as a means of raising some important health psychology issues. *Somatization* refers to complaints about, or the appearance of, physical symptoms such as headaches, stomach pains, inability to concentrate, chronic fatigue, sleep difficulties, loss of sensory functioning, and so on that have a strong psychological basis.[1]

Examining somatization is important for several reasons. First, somatic symptoms may have psychological as well as physical determinants; the interactions of these determinants are clearly germane to health psychology. Second, a controversy exists over the prevalence of somatization. Considerable impressionistic evidence suggests that somatization is more prevalent among Asian-Americans than among Westerners (Kleinman, 1977; Tseng, 1975). Analysis of the prevalence of somatization may be instructive in gaining insight to the complexities of ethnic comparisons in health status. Third, the role of culture in health and in the expression of symptoms is particularly salient in the analysis of somatization. Finally, implications for health practices (prevention, assessment, and treatment) can be drawn.

[1]The definition used here is not confined to somatization disorder, which is a psychiatric condition manifested by multiple physical complaints that have no physical basis.

In this chapter, we argue that little empirical evidence exists to support the notion that Asian Americans have a higher prevalence of somatization; that theoretical formulations attempting to explain the phenomenon of somatization, especially among Asian Americans, have failed to distinguish between disease and illness behavior; and that understanding illness behavior and cultural values can aid in the delivery of effective health interventions.

SOMATIZATION IN THE WEST

Somatization is a common phenomenon in Western societies. Lipowski (1988) defines it as "the tendency to experience and communicate somatic distress and symptoms unaccounted for by pathological findings, to attribute them to physical illness, and to seek medical help for them" (p. 1359). Somatization also exists in the form of amplified symptom expression among people with real medical problems that are often chronic, such as cancer or arthritis. Epidemiological studies in the United States and Europe have estimated the prevalence rate of somatization to be between 12% and 28% (Birdes & Goldberg, 1985; Schepank, 1988; Shepherd, Cooper, Brown, & Katton, 1966). In the past 2 decades, somatization has been the focus of much research because the medical community began to recognize it as a costly phenomenon (Engel, 1977; Katon, Ries, & Kleinman, 1984). More than 50% of primary care visits are made by somatizers who often undergo unnecessary medical exams, surgeries, and procedures, which are not only costly but also damaging to their health (Katon et al., 1982). Thus somatization is an important health care issue with significant fiscal, medical, and psychological relevance.

Researchers have offered many explanations of why people manifest somatic symptoms without medical cause (Katon, 1982; Kellner, 1990; Kirmayer, 1984; Mechanic, 1979). According to Simon (1991), the numerous etiological explanations can be summarized into four basic models. The first model, based on traditional Freudian theory, proposes that somatization is a *psychological defense*. Physical-symptom reporting and health-care seeking are viewed as altered presentations of psychiatric disorder, usually affective or anxious in nature. Therefore, somatization is a "masked" presentation of psychopathology. The second model conceptualizes somatization as a *nonspecific amplification of distress*. Manifestation of both physical and psychological symptoms is viewed as

the consequence of nonspecific underlying distress. This model predicts that patients who tend to perceive and report unpleasant sensations will endorse higher levels of all types of symptoms. The third model conceptualizes somatization as a *tendency to seek care for common symptoms* (Simon, 1991). This model assumes that unpleasant physical symptoms are ubiquitous and that negative affective states cause people to seek health care for symptoms they might otherwise ignore. Mechanic (1972) found that psychological distress caused somatizing patients to interpret common bodily sensations as evidence of disease. Mechanic viewed this tendency as a learned pattern of coping with emotional distress by focusing on bodily symptoms and seeking health care. The final model presented by Simon (1991) suggests that somatization is a by-product of the medical care system and other social institutions that selectively attend to physical symptoms. Such *selective attention* often contribute to iatrogenic damages, which are medical damages induced by unnecessary or exessive medical treatments.

SOMATIZATION IN ETHNIC ASIANS[1]

Research in cross-cultural psychiatry suggests that somatization is a more common phenomenon in non-Western cultures, including ethnic Asians living in Asia and in the United States (Kirmayer, 1984). While explanatory hypotheses concerning somatization among ethnic Asians are not inconsistent with the conceptions of somatization in Western societies, researchers have emphasized different cultural values or practices that encourage somatization. In general, these cultural hypotheses propose that certain aspects of Asian cultures facilitate the development of somatization. Ethnic Asians, especially the ethnic Chinese,[2] are thought to deny the experience and expression of emotions, either consciously or unconsciously (Cheung, in press; Kleinman, 1977; Nguyen, 1982; Tseng, 1975). Open displays of emotions are discouraged in order to maintain social harmony or avoid exposing personal weakness. Also, because of the heavy social stigma of mental illness, psychological distress is more readily expressed through the body rather than through the mind (Kleinman, 1977; Nguyen, 1982; Tseng, 1975). Somatic expressions of psychological distress thus constitute the socially recognized and accepted signals of illness. This cultural hypothesis is, in essence, very similar to the psychological defense model of somatization.

[1]Ethnic Asians refer to all those of Asian descent living both in and outside of Asia. Ethnic Asians include Asians living in the United States (i.e., Asian Americans).

[2]Ethnic Chinese refer to all those of Chinese descent living both in and outside of China, Hong Kong, and Taiwan.

Alternatively, because most Asian cultures traditionally hold a holistic view of mind and body, a clear differentiation between the psychological and somatic systems does not exist among many ethnic Asians (Tseng, 1975). Many of the indigenous expressions of psychological states metaphorically describe the states of various bodily organs. Furthermore, Chinese medicine, which has dominated traditional medicine in most of Asia for centuries, emphasizes the balance of two energy forces, yin and yang, as the key to good bodily and mental health. According to Chinese medicine, human problems can disturb the balance of yin and yang. Once an imbalance between yin and yang is created, it should be treated through both mind and body. The philosophy of mind and body of traditional Chinese medicine has had a tremendous influence on ethnic Asian patients' knowledge and conceptualization of their problems. Lastly, Leff (1981) made a controversial reference to the stages of ontogenic development of cultures. He explains that somatization commonly occurs in cultures that are still "primitive" such as those of Asia and Africa, whereas in the more "civilized" Western cultures psychological distress is expressed through psychological symptoms.

Prevalence of Somatization among Ethnic Asians

What do empirical findings suggest about the prevalence of somatization among ethnic Asians? Is somatization really as common as these cultural hypotheses suggest? Considerable research has been done with ethnic Chinese psychiatric patients (Kleinman, 1977; Lin, 1953, 1982; Rin, Schooler, & Caudill, 1973; Tseng, 1975; Tseng & Hsu, 1970). Tseng found that nearly 70% of the psychiatric outpatients at a psychiatric clinic in Taiwan presented with exclusively or predominantly somatic complaints on their initial visit. Similar observations were made across age and socioeconomic status in Chinese Americans living in Boston's Chinatown area (Gaw, 1976). Kleinman (1977) compared symptom presentations of 25 Chinese and 25 American psychiatric patients with depressive syndromes. He found that 88% of the Chinese patients initially reported somatic complaints but no affective complaints, compared with only 20% of the American patients. Somatic complaints were also much more common among Thai depressive patients and Vietnamese soldiers than among European depressive patients residing in Thailand and American soldiers in Vietnam, respectively (Bourne & Nguyen, 1967; Tongyonk, 1972). These findings suggest that somatization is more prevalent in ethnic Asians than in people with European ancestry.

Further evidence of greater somatization among ethnic Asians comes from cross-cultural research on neurasthenia. In China, *shenjing shuairuo*, or neurasthenia, is the most commonly diagnosed psychiatric disorder (Kleinman, 1980, 1982; Ware & Kleinman, 1992; T. Y. Lin, 1982). It is also a widely recognized and used psychiatric lay term in China, Hong

Kong, and Taiwan (T. Y. Lin, 1989) and implies "an ailment with vague, protean signs and symptoms due to weakness of the nervous system, the brain, and the body generally, in which bodily weakness, fatigue, tiredness, headaches, dizziness, and a range of gastrointestinal and other complaints are to be found" (Kleinman, 1982, p. 82). Kleinman found that of the 100 Chinese psychiatric patients diagnosed with neurasthenia he interviewed in China, 93% suffered from various forms of clinical depression and 71% from anxiety disorders (although actual diagnosis of depression was very rare). These neurasthenic patients reported the somatic symptoms of depression and anxiety but suppressed most of the affective symptoms. Kleinman thus argues that, in China, neurasthenia is a culturally sanctioned expression of psychiatric disorder, mainly depression and anxiety. Once again, the implication is that ethnic Chinese tend to somatize their psychiatric disorders.

Research in cross-cultural psychiatry has also "discovered" culture-bound syndromes that are primarily somatic in nature. *Hwabyung* is a somatic disorder found among ethnic Koreans (K. M. Lin, 1983; K. M. Lin et al., 1992). Literally, *hwabyung* means "anger sickness" or "fire sickness" and consists of "a multitude of somatic and psychological symptoms, including constricted, oppressed, or 'pushing-up' sensations in the chest, palpitations, 'heat sensation,' flushing, headache, 'epigastric mass,' dysphoria, anxiety, irritability, and difficulty in concentration" (K. M. Lin et al., 1992, p. 386). Based on the investigation of the symptomatology of *hwabyung* and the psychiatric history of Korean Americans who have experienced *hwabyung*, K. M. Lin and his colleagues concluded that *hwabyung* may be a culturally bound somatic expression of major depression.

Koro is a culture-bound syndrome found primarily in Chinese and Southeast Asian cultures. It is conceptualized as a nervous disease because it causes certain nerves to contract. The contraction of the nerves results in shrinkage of the genitals. *Koro* occurs more commonly in men, although *koro* in women has been reported. Men who suffer from *koro* complain about their penis shrinking and fear impending death (Edwards, 1984). *Koro* attacks are said to be random but usually occur after a shock treatment to the patient that causes fear or anxiety or as a result of physical overexhaustion. Other symptoms of a *koro* attack are very similar to those of a panic attack. They include sudden increase in heart rate, palpitations, numbness in the extremities and limbs, fainting, and fear of dying (American Psychiatric Association, 1994). Therefore, *koro* may be viewed as a culturally bound somatic expression of anxiety, fear, or both, in ethnic Chinese and Southeast Asians.

In sum, much of the early cross-cultural research on somatization and the more recent research on neurasthenia and culture-bound syndromes suggest that somatization is quite prevalent among ethnic Asians and possibly more prevalent than among Euro-Americans.

Problems with Cross-Cultural Research in Somatization

While the findings of these early studies provide some support for a higher prevalence of somatization among Asians, there have been conceptual and methodological problems with the cross-cultural research in somatization. First, the definition of somatization is not clear. Somatization has been operationally defined in such various terms as somatic complaints, endorsement of somatic symptoms, initial reporting of somatic symptoms, diagnosis with a somatic disorder such as neurasthenia, and so on (Gaw, 1976; Kleinman, 1977, 1982; T. Y. Lin, 1982; Tseng, 1975). Recently, there have been efforts to refine the definition of somatization (Cheung, 1985 cited in Cheung, in press; Kleinman & Kleinman, 1985). Cheung (1985, cited in Cheung, in press) defined somatization as "the presentation, complaint, or manifestation of somatic symptoms that relate to psychological or emotional problems." This revised definition of somatization may appear to be tautological with the psychological defense model of somatization that conceptualizes somatization as a masked expression of underlying psychological distress. However, it should be noted that Cheung's revised definition does not imply how or why such masking occurs, whereas the psychological defense model states that the masking of underlying psychological distress occurs as a result of internal psychological defenses such as denial, repression, or suppression of emotions.

Kleinman and Kleinman (1985) expanded their definition of somatization by adding the medical-help-seeking component of the phenomenon. Furthermore, they made the distinction between acute, subacute, and chronic somatization. *Acute somatization* refers to temporary somatic complaints and medical help seeking caused by acute life stressors. *Subacute somatization* is a more serious condition that lasts several months and is caused by either persistent stressful life circumstances or a psychiatric disorder such as depression or anxiety. *Chronic somatization*, on the other hand, often consists of physical symptoms of a psychiatric disorder or amplified expression of a chronic medical disease such as arthritis or heart disease. Lipowski (1988) argues that acute somatization is a common and normal response to stress and that only chronic somatization should be considered as a clinical disorder. With the exception of studies on neurasthenia and depression in ethnic Chinese (Kleinman & Kleinman, 1985; Ware & Kleinman, 1992), investigations on somatization in ethnic Asians often failed to distinguish the various types of somatization.

Second, related to the problems of definition, early studies failed to make a distinction between symptom reporting and symptom manifestation (Cheung, in press). Many of them relied solely on patient self-report. One major drawback of self-report is that ethnic-Asian participants tend to hold back information or not report symptoms that may cause themselves or their families shame (e.g., marital conflict, psychotic symptoms,

academic or job failure; Uba, 1994). Because of the shame that psychological disorders carry in Asian cultures, subjects in the early studies who were asked to report symptoms may have selectively reported only the somatic symptoms that appeared to have a physical cause. Such selective reporting could certainly give researchers the impression that ethnic-Asian psychiatric patients somatize. In fact, recent studies have found that many of the ethnic-Asian patients who initially reported only somatic complaints also report psychological symptoms when directly probed (Cheung, 1982; Cheung, Lau, & Waldman, 1980; Lin, Masuda, & Tazuma, 1982; Nguyen, 1982; Zheng, Xu, & Shen, 1986). Thus initial reporting of somatic symptoms should not be taken automatically as evidence for a lack of psychological insight or awareness.

Third, most of the early findings on ethnic Asians are descriptive and anecdotal (Kirmayer, 1984). Some reports were based on the clinical experience of the authors (T. Y. Lin, 1982) and some on clinical case analyses (Kleinman, 1977; Nguyen, 1982; Ware & Kleinman, 1992). Others simply reported frequency counts and percentages of people with somatic complaints or number of people who endorsed a particular symptom (Kleinman, 1977, 1982; Nguyen, 1982; Tseng, 1975) Although good descriptive information, impressionistic data, or both can help us develop critical hypotheses, there must be empirical testing of the cultural hypotheses that have been put forth.

Fourth, conclusions drawn from these early findings may be misleading because these studies included only psychiatric patients. As a result, there may have been some selection biases in the samples. For example, Asian psychiatric patients compared to other ethnic patients tend to avoid mental health services, fearing stigmatization. Consequently, they are likely to be more seriously disturbed than other patients. Or individuals with somatic problems may seek medical treatment, whereas those with psychological problems may seek help from other providers such as acupuncturists and herbalists, from nonprofessionals (e.g., spiritual/religious leaders, friends, family), or not seek help at all. If these self-selection and sampling problems are not controlled, comparisons of the prevalence of somatization among different groups cannot be adequately performed.

In fact, recent studies investigating somatization in nonclinical community samples of Asians and Asian-Americans found that somatization is not more prevalent in Asians and Asian-Americans than in ethnic Europeans (Beiser & Fleming, 1986; Cheng, 1989). Kagawa-Singer and her colleagues (under review) interviewed Asian- and Euro-American women with breast cancer using several structured interview measures and found that the number and the type of somatic symptoms not attributable to their medical condition did not differ between the two groups of women. In an epidemiological study in Taiwan, Cheng measured the prevalence rates of somatization to be 19.6% for males and 27.1% for

females. Cheng compared these rates to those in the British survey by Jenkins (1985) and from other Western surveys (Woodruff, Murphy, & Herjanic, 1967; Mathew, Weinman, & Mirabi, 1981) and found that they were not different from one another. Raskin, Chien, and K. M. Lin (1992) found that contrary to their hypothesis, which predicted more reporting of somatic complaints in elderly Chinese Americans compared to elderly European Americans, elderly Chinese Americans actually reported less somatic complaints than their Caucasian counterparts. In a later paper, even Kleinman and Kleinman (1985), who originally claimed that somatization was more common among ethnic Chinese, acknowledged that somatization was also very common in the West.

In conclusion, there is insufficient evidence to support the claim that ethnic Asians somatize more than ethnic Europeans (Cheung, in press; Kirmayer, 1984; Singer, 1975). In fact, more recent research evidence suggests that what we saw in the early reports of somatization in ethnic Asians were artifacts of methodology (e.g., poor and inconsistent operational definition of somatization, inadequate sampling strategy, and insufficient probing for psychological symptoms). As mentioned above, many of the early reports did not distinguish between discomfort reporting (or illness behavior) and symptom manifestation. Cheng (1989) warned that the term *somatization* should be used only when primary psychological symptoms are not found in spite of adequate clinical assessment. When reporting bias is controlled for by conducting structured interviews, nonpsychiatric populations are studied, and the prevalence rates of ethnic Asians and ethnic Europeans are directly compared, at least in terms of prevalence, then the phenomenon of somatization in ethnic Asians is not exceptional. What appears to be exceptional in ethnic Asians is the highly common physical symptom-reporting and medical-help-seeking behaviors.

UNDERSTANDING SOMATIZATION IN ETHNIC ASIANS

Despite revealing new evidence, some of which has been mentioned above, it is interesting to note that the myth of greater somatization in ethnic Asians persists. The persistence of the myth is partly due to inadequate dissemination of the new evidence. However, the main fuel for its perpetration appears to be what caused the emergence of the myth in the first place. That is, regardless of their awareness of the psychological nature of their problems, ethnic Asians initially tend to report more somatic complaints and seek medical help for their somatic problems more frequently than do ethnic Europeans.

The clinical implication of this phenomenon is that there is a greater burden on health care providers seeing Asian-American patients to identify patients who may be presenting psychogenic somatic symptoms. This

task requires health care providers to understand the meaning of somatic complaints in the Asian-American population. Such understanding should be based on knowledge accumulated not only from clinical experience but also from systematic and well-defined research. Fortunately, the recent studies of somatization in ethnic Asians have gone beyond estimating prevalence rates and have begun to systematically investigate the phenomenon, ultimately searching for etiological factors that may be influenced by culture. The following discussion is our attempt to provide a brief overview of these studies within a common theoretical framework and shed some light on the phenomenon of somatization in ethnic Asians.

Somatization as an Illness Experience

The distinction of illness experience/behaviors from disease has helped recent efforts to improve research on the phenomenon of somatization, especially in ethnic Asians. The disease/illness distinction originally began in the medical field in order to understand symptoms and behaviors of chronically ill patients that are not directly caused by the biological disease (McHugh & Vallis, 1986). *Disease* simply refers to physical ailments or conditions that require medical attention such as cancer, arthritis, and hepatitis. *Illness*, however, refers to one's reaction to, interpretation of, and coping with the disease. Illness can also be described as the psychosocial experience of the disease. Recognizing the limitations of the biomedical model of disease that attributes physical conditions and ailments only to "disordered biology," McHugh and Vallis proposed a biopsychosocial model—the illness behavior model—which integrates both the disease and illness experiences of an individual. It has been proposed that somatization phenomena observed in ethnic Asians may be better explained as illness behaviors (Cheung, in press; Kleinman, 1982; Kleinman & Kleinman, 1985; Ware & Kleinman, 1992).

According to the biomedical model, a disease shares a universal etiology and manifestation (McHugh & Vallis, 1986). Thus, the conceptualization of somatization as a disease would be relatively *culture free*. That is, somatization in the United States is caused by the same factors and is manifested in the same way as somatization in Indonesia. This is the model under which health and mental health care providers commonly operate (Kleinman, 1980). In the fourth edition of the *Diagnostics and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 1994), somatization appears to be conceptualized more as a disease, and the manual lists the criteria of various somatoform disorders. Although the DSM-IV acknowledges some cultural variations of the disorders, the main assumption is that these criteria will be relatively universal.

The illness behavior model, on the other hand, pertains to the experience of disease and acknowledges the influence of the ethnocultural context on the individual (McHugh & Vallis, 1986). According to the illness behavior model, diseases may be universal, but the illness experience accompanying each disease varies from person to person. Illness experience is a set of cognitions and behaviors occurring in reaction to a disease. The illness experience begins with cognitive appraisals of a problem situation (e.g., depression, anxiety, or interpersonal conflict). These cognitive appraisals are influenced by both internal and external factors, such as past learning experience related to illness and social support. Once the situation is considered distressing, coping responses that broadly consist of self-care and help seeking will follow. Sociocultural factors, such as attitudes toward experience of distress and the socially normative treatment of distress, comprise the ethnocultural context that influences the components of the illness experience.

Somatization as an illness occurs in reaction to the underlying disease that can be either life stressors (e.g., unemployment and marital conflict) or psychopathology (e.g. depression and anxiety) (Cadoret, Widmer, & Troughton, 1980; Katon, 1982; Katon, Kleinman, & Rosen, 1982; Kleinman, 1982; Kleinman & Kleinman, 1985). Illness behaviors often take the form of medical help seeking and somatic-symptom presentation. Such illness behaviors are fairly common and even adaptive in both ethnic Asians and ethnic Europeans. However, in some individuals these behaviors persist beyond the negative results of thorough medical examinations and thus become maladaptive. In China, somatization is implicitly understood as an expression of underlying psychological distress or pathology but labeled as a disease (i.e., neurasthenia; T. Y. Lin, 1982; Kleinman & Kleinman, 1985). Kleinman and Kleinman concluded that neurasthenia is a cultural label of somatization, which, in turn, is an illness behavior of "masked depression."

It has been demonstrated that the illness model lends itself to investigations of the ethnocultural influences on somatization, whereas the biomedical disease model places its emphasis on the universal aspects of somatization. The reconceptualizion of the phenomenon of somatization in ethnic Asians as an illness enabled the examination of the specific illness aspects of the phenomenon (Cheung, Lee, & Chen, 1983; Cheung, 1987; Cheung & Lau, 1982; Kleinman, 1982; Kleinman & Kleinman, 1985; Ware & Kleinman, 1992). This approach has advanced our understanding of the ethnocultural influences on somatization by shedding light on how ethnic Asians conceptualize their problems and how these conceptualizations guide the expression of distress, coping, and help-seeking behaviors.

Problem Conceptualization and Symptom Presentation

In the past, the cultural hypotheses stated that ethnic Asians tend to conceptualize their problems mainly in somatic terms and that their conceptualization contributes to their somatic experience and reporting

of psychological distress (Kleinman, 1977; Tseng, 1975). However, recent research indicates that somatic symptoms are not necessarily alternative channels for expressions of distress because psychiatric symptoms and somatic symptoms were often found to co-occur (Cheung, Lau, & Waldmann, 1980-81; Lin, Masuda, & Tazuma, 1982; Nguyen, 1982). In fact, exclusive manifestation of somatic symptoms is quite rare. Most patients acknowledge the presence of both somatic and psychological symptoms, but often do not see the link between their physical complaints and psychological distress (Lin, Masuda, & Tazuma). Furthermore, studies investigating problem conceptualization in ethnic Chinese revealed that ethnic Chinese have a multitude of different conceptualizations of their problems that can be broadly categorized as psychological, somatic, and situational (Cheung, 1987; Cheung, Lee, & Chen, 1983).

If ethnic Asians conceptualize their problems in various ways including somatic and psychological, why do researchers repeatedly observe ethnic Asians in psychiatric settings presenting with somatic complaints? Researchers have found that the symptom-reporting behaviors of ethnic Asians may be context-dependent. Ethnic-Chinese patients reported only somatic symptoms to their primary care physicians despite their awareness of psychological symptoms (Cheng & Lau, 1982). Even when they were seen by a psychiatrist, these patients limited their reporting to somatic symptoms because they thought psychiatry treated only problems related to the brain such as headaches and dizziness (Tseng, 1975). In fact, Tseng explained that until recently psychiatry was called "neuropsychiatry" in both China and Japan. In Korea, the term is still being used. Thus, as Kirmayer (1984) suggested, patients' knowledge of psychiatric medicine also contributes to their selection of which symptoms to report.

Coping and Help Seeking

In addition to symptom-reporting behaviors, problem conceptualization also appears to influence the coping and help-seeking behaviors of ethnic Asians. In an investigation of illness behaviors of Chinese college students, Cheung and her colleagues (1983) found that problem conceptualization is related to coping and help-seeking behaviors when the problem is not serious. That is, if the problem was conceptualized mainly in somatic terms, then the student subjects indicated that they would change their somatic states by modifying their diet or doing more exercise. On the other hand, if the problem was conceptualized in both somatic and psychological terms, then the subjects offered both psychological and somatic solutions such as relaxing, changing social and physical lifestyle, and so on. For serious problems, however, the solution was unanimously "seeking medical care" regardless of the subjects' initial problem conceptualizations. Ethnic-Chinese college students reported

that for serious problems they would seek professional help from primary care physicians and occasionally from traditional Chinese medicine (Cheung et al.). Even for mild problems, a substantial minority answered that they would consult primary care physicians. Cheung and her colleagues thus concluded that primary care physicians are regarded by ethnic Chinese as professionals to whom they may turn for many different problems.

In contrast, psychiatric care is seldom sought by ethnic Chinese. In the same study by Cheung and her colleagues (1983), even individuals who conceptualized their problems psychologically rarely indicated that they would seek or had sought help from mental health care providers. In fact, they preferred self-care coping strategies that included relaxing, ignoring the problems, or changing their social lifestyle and seeking social support from families and friends (Cheung, 1987; Cheung et al., 1983). Despite the psychological nature of the problems, when these strategies fail to alleviate distress, medical help is sought. One hundred percent of the ethnic Chinese psychiatric patients interviewed in a retrospective study (Cheung) indicated that they had been referred to psychiatric care by their primary care physicians.

This fact does not imply that all individuals seeking medical care for their psychological problems will eventually be referred to psychiatric care. In fact, many of the psychiatric patients, especially those who primarily conceptualized their problems somatically, had frequently changed their physicians because of lack of improvement in their somatic problems (Cheung, 1987; Kleinman, 1985). This "doctor shopping" caused long delays before these individuals consulted psychiatric care. From these findings we can deduce that some patients may never get referred to psychiatric care if their physicians fail to detect the psychosocial nature of their problems. Unfortunately, we know very little about these individuals.

In conclusion, the early impression that ethnic Asians somatize more than ethnic Europeans seems to be associated with particular coping and help-seeking behaviors of ethnic Asians rather than to a tendency to conceptualize problems somatically. In fact, as demonstrated by Cheung and her colleagues (Cheung, 1987; Cheung et al., 1983), ethnic Asians do not limit their conceptualization to somatic terms. By understanding the disease–illness distinction and the cultural conceptions of illness, we can gain insight into the means of devising effective treatment and intervention programs and into the important directions for future research.

IMPLICATIONS FOR CLINICAL PRACTICE

Reconceptualizing somatization as an illness has important clinical implications for health care providers because ethnic Asians tend to seek

medical help for problems that are not only somatic in nature but also psychological and social (Cheung, 1987; Cheung, Lee, & Chan, 1983). The clinical implications can be divided into three general areas: assessment, treatment, and prevention of somatizing illness behaviors of ethnic Asians.

Assessment

Because research findings show that ethnic Asians tend to present only somatic symptoms to primary care physicians and psychiatrists for problems that are actually psychogenic, health care providers need to exercise care when assessing the physical health of Asian-American patients. Given the research findings, it would be tempting to conclude that the Asian-American patient is exhibiting somatization illness behaviors when the medical cause of the presented problem is not obvious. A comprehensive interview can prevent health care providers from making diagnostic errors that are based on stereotypical assumptions and can help them assess whether the patient's symptoms are truly due to organic causes only or are illness behaviors of psychological distress or psychopathology other than somatization disorder.

Nevertheless, health care providers need to be sure to probe for possible psychological symptoms related to memory, concentration, and affect that Asian-American patients may not report since studies have found that many of the so-called "somatizers" do admit having psychological symptoms when asked. A structured and comprehensive interview that covers both somatic and psychological symptoms can ensure that such psychological symptoms, if present, do not go unnoticed by practitioners.

The interview may also contain questions regarding the patient's medical treatment history and presence of life stressors. The medical treatment history might reveal the patient's utilization pattern of the health care system. This information can help health care providers identify possible somatizers whose medical treatment history would reveal a pattern of "doctor shopping." Inquiry into past and present life stressors can provide information about what factors precipitated health care utilization. In the cases of patients with real medical problems, the deterioration in their physical condition or appearance of new physical symptoms may have caused them to seek medical care. On the other hand, patients with somatic symptoms that are psychogenic will have experienced some kind of stressful life event or circumstance immediately before the onset of the somatic symptoms or seeking of medical care.

Treatment

Research on somatization in ethnic Asians also has important implications for treatment of Asian-Americans. The evidence demonstrates

that ethnic Asians, including Asian-Americans, often hold conceptualizations of their problems that differ from mainstream Western medicine and psychiatry. Unfortunately, for effective, culturally responsive health care services, it is critical that the patient and the health care practitioner share, or at least understand, each other's conceptualizations of the patient's problem. Meichenbaum (1976) notes that when there is incongruity in problem conceptualization between the patient and health care provider, patients are less likely to engage in treatment. If, for example, Asian-American patients believe that their somatic symptoms are caused by an imbalance in hot and cold energy, the patients may resist referrals to mental health care providers. Therefore, in order to facilitate treatment compliance and efficacy, the treatment should initially accommodate the patient's conceptualization of the somatic symptoms (Simon, 1991).

If the patient's problem is identified as somatization illness behavior, the treatment should target the underlying psychological distress or psychiatric disorder. However, the somatizing patient should be "eased" into the psychological treatment by implementing the treatment in primary health care settings, in conjunction with medical services. This process will help reduce the resistance of somatizing patients to psychological interventions. Thus, an ideal treatment for somatization would entail interdisciplinary work between health and mental health professionals.

One such treatment program that has been implemented in primary health care settings is a group treatment program designed by Barsky, Geringer, and Wool (1988). This treatment program has a psychoeducational (i.e., behavioral and cognitive) and supportive orientation. The behavioral component consists of distraction and relaxation techniques that assist patients to reduce sensitivity to bodily sensations. The cognitive component consists of teaching somatizers to reattribute physical sensations to benign causes such as cold and fever. Supportive discussions of life stress and situational factors have repeatedly been found to be helpful, especially to relieve the overall psychological distress. This component may be very important because Kleinman and Kleinman (1985) reported that almost all of the neurasthenic patients they interviewed in the study had experienced stressful life events in the 6 months prior to the onset of their symptoms. Treatment of this nature considers somatic symptoms to be genuine expressions of distress and deals with somatic symptoms not as a defense against the real problem but rather as a real problem (Simon, 1991).

Prevention

Preventive efforts should focus on educating the Asian-American community about the psychogenic nature of some somatic problems. Although somatic expressions of distress are not necessarily abnormal or dysfunctional (Kleinman & Kleinman, 1985), awareness of the dangers of

developing maladaptive somatization behaviors that can lead to chronic dependence on health care and iatrogenic damages should be raised in the Asian-American community. Such awareness can minimize unnecessary medical treatment and reduce the delay to appropriate mental health care. Because studies have shown that regardless of how problems are conceptualized ethnic Asians seek professional help from primary care physicians for serious problems, education about available mental health services and the nature of mental health services and psychiatric care are necessary to reduce delay to appropriate care

IMPLICATIONS FOR RESEARCH

Our discussion points to a need for greater understanding of somatization among Asian Americans. First, we need more detailed descriptions of the illness phenomenon in Asian Americans, for example, the nature of somatic complaints, frequency or intensity of somatic symptoms, underlying disease, and the course of the illness. Because findings have largely been derived from the Chinese and some from Southeast Asian refugees, the generalizability of results is thus open to question. Therefore, we need more descriptive data on other groups of Asian Americans.

Second, more sophisticated research designs involving tests of specific hypotheses are needed to identify the specific cultural factors that influence the medical help-seeking behaviors in Asian Americans. Various cultural factors such as collectivistic values (e.g., shame/loss of face), attitudes toward mental illness, and culturally transmitted coping behaviors have been proposed in the past, and some work has begun with the Chinese population in Hong Kong, but not with Asian Americans who are distinctly different because of their biculturality.

Third, research indicates that most ethnic Chinese who seek psychiatric care go through the primary health care system at some point in their attempts to cope with their problems. Investigations into this particular phase of the illness can provide valuable information for designing and implementing prevention and treatment programs.

Fourth, we need to find out what happens when Asian Americans seek nonprofessional help. For example, we know very little about how they seek help from family and friends or mobilize social support. And we know even less about what kinds of help Asian Americans seek from the nonprofessionals and how effective nonprofessional help is.

Finally, we need research on the culturally sensitive assessment, treatment, and prevention of somatization illness behaviors for Asian Americans. This reserach should look at both the innovation and efficacy of new procedures and programs.

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