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# 'Wind Illness' or Somatic Depression?
## A Case Study in Psychiatric Anthropology

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**Summary:** A 46-year-old mother with a history of chronic headaches and other symptoms, and a clinical diagnosis (in Western terms) of depression, ascribed her condition to non-observance of Chinese postpartum ritual. The characteristic features of 'wind illness' are described. Western medicine proved useless but acupuncture was beneficial. The case underlines the importance of understanding the patient's own view of his/her illness and its causes in arriving at a correct diagnosis and intervening effectively: this is particularly true when the gap between the doctor's and the patient's cultures is wide. The value of the distinction between the *disease* (the pathological process, which may be universal) and an episode of *illness* (the personal and cultural construction of disease) is emphasized.

I met Mrs Xuyen, a 46-year-old mother of six, when I called to see her 17-year-old son, who had been reported as suffering from severe depression at school. All available members of the family crowded into the living room—males and females, young and old—and engaged in voluble talk. From time to time, individuals would move about to join groups. At each of my visits, Mrs Xuyen sat huddled in a corner, head averted, her face showing a pained expression. She seemed to have no comprehension of what was going on around her and nobody paid her any attention apart from one niece. This niece, who lived in another household, was always present when I visited: she would sit on the arm of Mrs Xuyen's chair, embracing her and seeming to offer solace, protection and contact.

At first it appeared that Mrs Xuyen's withdrawn behaviour might be acceptable as normal within her own culture, but she remained so persistently unresponsive that I came to believe that she was clinically depressed. This was indirectly confirmed by isolated casual remarks about her made by her children. Reference was made to her bad 'headaches' and numerous other varied bodily pains, to which family members seemed well-accustomed. There was no sense of urgency, or concern that Mrs Xuyen might be ailing, although she had suffered severe headaches for many years. Their onset had coincided with a period of chronic family stress said to be due to the war in North Vietnam: the family had lost their house, possessions and livelihood, and had been forced to migrate within Vietnam. A doctor had prescribed tablets, but nobody could recall what they were for. With the trauma of resettlement in England, Mrs Xuyen's headaches became so severe that she was almost incapacitated and her niece visited daily to look after her and care for the family. Mrs Xuyen had no faith in Western medicine, and it was only as a result of considerable pressure from the younger members of her family that she finally agreed to see a general practitioner, who diagnosed tension headache and prescribed a course of self-relaxation. Mrs Xuyen emerged from this meeting bewildered and disappointed. Despite the help of an interpreter, she had understood nothing of what had occurred and could see no possible connection between her headache and the prescribed exercise. Nor could she understand why she should now attend the regional hospital to have blood taken from her arm, and for X-rays: in Vietnam, such things happened only in direst illness.

Mrs Xuyen's headaches showed no improvement. They were also associated with insomnia, anorexia, loss of weight, distractibility, inability to concentrate and lack of interest in housework, in her children or in herself, suggesting a diagnosis of depressive illness rather than anxiety or tension headaches.

Because of the cultural gap between Mrs Xuyen and any Western observer, it seemed to me to be important to gain information about *her* perception of the nature and origin of her symptoms. She believed, for example, in the power of bad spirits, and it seemed possible that her concepts of health and illness might be based upon notions of humoral imbalance characteristic of Buddhist, Taoist and Confucian cosmologies.

As the weeks passed, Mrs Xuyen made no attempt at the relaxation exercises, but she did make passing reference to 'wind'. Reviewing the history of her headaches, it was learned that their onset dated back sixteen years, far earlier than I had realized. The initial problem was not in fact a headache, but 'something bad'. She explained that after the birth of her third youngest child, she had failed to observe the ritual of 'doing the month'. Consequently, she had become poisoned, and her headaches were a final manifestation of this poisoning. Mrs Xuyen explained that when she was 'dirty' after having delivered the child, she had cleansed herself with a wet towel, and rinsed it out in clean water. Feeling fatigued, she lay down to sleep, placing the moist towel under her head as a pillow. During her sleep, the 'wind' emerged from the towel and entered her head, where it had stayed ever since. It is noteworthy that, of the entire sibship, this child, whom I was first called on to see, is the only one to have developed depressive symptoms and headaches during his childhood. These symptoms have become more pronounced with adolescence. Mrs Xuyen's attitude was fatalistic. She considered that she had already done everything possible to make amends for her carelessness, even trying to right the wrong by more carefully following the ritual of 'doing the month' after the birth of two more children. Herbal remedies had also failed, and she was convinced that there was nothing that she, Western practitioners, or anyone else, could do to reverse the situation.

A Vietnamese doctor, well versed in traditional healing, confirmed that headaches caused by 'wind' were notoriously difficult to treat, but Mrs Xuyen willingly commenced a course of acupuncture. After the fourth or fifth treatment, her headaches had diminished and she had become increasingly involved in family life. Her insomnia, however, persisted.

### Chinese postpartum rituals

Chinese traditional custom stipulates that a woman should spend a month's convalescence confined to the home after giving birth. During this time she is expected to observe restrictions and proscriptions, referred to as 'doing the month'. Three general principles that emerge from a multitude of details are: anything that might cause disease and specific ailments in the future should be avoided; foetal blood must not be allowed to contaminate others or offend the gods; and hot food (not cold) should be eaten.

These practices are intended to be curative and preventative, but in view of the number of rules and their complexity, it is unlikely that they are always strictly adhered to for the entire month. Failure to 'do the month' correctly leads *ex post facto,* to chronic illness much later in life. Such an affliction may be forestalled by becoming pregnant again to provide the chance to make restitution by 'doing the month' more scrupulously next time.

The cosmological basis to this practice has been the focus of much recent speculation (Gould-Martin, 1978; Pillsbury, 1978; Topley, 1974). Some sources suggest that a poisonous disorder may be caused by contact during the first post-partum month with "queer" things such as brides, mourners, striking features of the landscapes, demons, and gods, all examples of the Confucian polarisation toward *yin* and *yang*. The catalytic effect of such a meeting of opposites is to produce a powerful 'wind'; a poison is thus generated and a poisonous disorder starts to incubate.

Later, when the disease erupts and declares itself, the sufferer can, it is supposed, contaminate a normally balanced person with her illness. This belief has considerable importance in handling such a condition in a Western clinical setting.

## Wind illness

'Wind illness' is one of the most common complaints in South-East Asian societies. The term may refer to any combination of organic pathology, psychosomatic disturbance and spirit possessions, disorders of the body, emotions and behaviour all coming under one diagnosis. There are thousands of varieties of wind illness, all treated by the same healers in much the same way.

The relevant cosmology holds that the human body, along with everything else in the universe, is composed of the four basic elements: *earth* (hair, nails and bones, which are hard); *water* (blood and bile, which are cohesive); *fire* (which provides heat and aids digestion); and *wind* (breathing, which causes movement). Imbalance between these elements causes illness.

There are several different points of view of the aetiology of 'wind illness'. Within Buddhist doctrine, the basic cause of all misfortune is bad *karma,* with illness having a fundamental moral significance. In the Confucian perspective, factors leading to humoral imbalance are emphasized: the calendar, the seasons and horoscopes are used by healers. Complementing these formal explanations are the folk beliefs in *spirit possession.* Considerable overlap exists between the presentations of wind illness and spirit possession, making differential diagnosis difficult. This disorder thus provides an example of the way in which explanatory beliefs about a syndrome come together to give not merely a case of multiple aetiology, but one of multiple pathogenesis.

It is possible to distinguish also various aspects of wind illness. First, the *cause* of wind disturbance: hunger, breach of postpartum custom, alcoholism,

spirit possession, or drug addiction. Second, the underlying humoral process: wind rises, falls, or gets stuck. Third, the *site* of the congested wind: nerves, chest, brain, eyes. Fourth, the *effects* of the wind disturbance: sharp pain, feelings of faintness, seizures, and episodes of violent or disoriented behaviour.

The category applying to Mrs Xuyen is 'wrong menstrual wind illness' (*lom phit duan*), caused during the first postpartum month by a maternal breach of postpartum customs; for example, smelling a bad odour, eating the wrong food, or bathing in cold water. 'Manifestations may be acute or chronic, but often they do not occur until . . . ten to thirty years afterwards. Thus (they are) usually diagnosed *ex post facto,* by the women recalling some previous breach of postpartum custom that explains a later occurrence of wind illness.' (Muecke, 1980).

A corollary of the association between parturition and 'wind illness' is that the illness may be transmitted by the breast milk of an afflicted mother. This useful explanation of how some males contract wind illness applies to Mrs Xuyen's son, born at the time she took in the 'wind', and later developing illness in his own right.

According to the indigenous healers, there are four precipitating factors which give rise to 'wind illness', the most dangerous of which is smelling a noxious odour. Poisonous substances enter the body by inhalation, directly with 'wind', and the resultant humoral imbalance produces 'wind illness'. Another cause is eating certain bad foods which, when ingested, affect the abdomen and chest: because wind is situated there, it then rises.

Mrs Xuyen believed herself to have absorbed the wind directly through her scalp by transferring the bad poison directly from her perineum. She had not needed to smell or eat the badness; hers was a far more direct portal of entry to her brain.

The two other precipitating factors are directly connected with the supposed vulnerability of the female sex. The first is their allegedly weaker 'life essence' which makes them less resistant to external stimuli. A specific factor is the impact of menstrual blood flow upon humoral balance: menopausal upsets are attributed to the retention of the element water, leading to disrupted equilibrium of wind. Multigravidae, such as Mrs Xuyen, are considered particularly vulnerable, possibly because of a combination of cumulative blood loss and advancing age. The other factor is a belief that women tend to brood and to have jittery nerves. The most severe forms of 'wind illness' supposedly occur when wind rises to the brain: when a person becomes anxious, depressed, or mad, this is seen as a concentration of disordered wind in the brain, the source of feelings and behaviour. Mrs Xuyen and her family explained not only of headaches, but all her symptoms in these terms.

## Discussion

Kleinmann (1980) has made a careful distinction between the 'explanatory models' (EMs) held by individual patients, and those held by different practitioners in the separate areas of health care systems. He defines explanatory models as 'notions about an episode of sickness and its treamnet that are employed by all those in the helping process.' Explanatory models are different from general beliefs about sickness and health care, which exist outside individual episodes of illness. In the case just described, Mrs Xuyen, the local community, the general practitioner, and I (initially) each held disparate explanatory models for Mrs Xuyen's headache. Understanding Mrs Xuyen's explanatory model, it was possible to harness the available resources more appropriately in offering help.

With the growth of interest in Eastern cosmologies, there has been a move toward explaining illness in South-East Asian patients within the framework of Confucian, Taoist or Buddhist philosphy. While I am sympathetic to such attempts at understanding I see two possible flaws in this approach. In the first place, the Vietnamese cannot be taken as a unit culture: they are a pot-pourri of Taoist, Confucism and Buddhist traditions, so that some Vietnamese are more under Chinese influence than others. The second problem is perhaps more challenging: it is to determine in any particular case just what the Vietnamese patient actually says about the aetiology of his/her symptoms. This point is often missed in otherwise illuminating accounts of symptoms which have been found in Vietnamese patients and inserted into a theoretical cosmological matrix for interpretation. Individual patients are usually unaware of the details of their 'great tradition', whereas the well-intentioned Western observer, having read the classic texts and surveys of Eastern medical philosophy, may superimpose his own construction of Eastern beliefs upon his pre-existent Western medical viewpoint. This may well distort, rather than clarify, his view of the patient's condition. I would therefore argue strongly for the value of meticulously exploring what the patient thinks to be the explanation of his/her symptoms.

From Mrs Xuyen's array of symptoms, one might be tempted to diagnose a depressive illness, but the disparity of cultures complicates matters. While it is possible in the West to isolate a 'depressive syndrome' characterized by a set of somatic and psychological symptoms, most cases of depression in fact lie outside such a narrow deinition. Kleinmann (1977) has pointed out that 'applying such a category to analyse cross-

cultural studies, or even in direct field research, is *not* a cross-cultural study of depression, because by definition it will *find* what is "universal" and systematically *miss* what does not fit in its tight parameters. The former is what is defined and therefore "seen" by a Western cultural model . . . (but) it is precisely in the latter group that one would expect to find the most striking examples of the influence of culture on depression.' Following this argument further, we may usefully make a distinction between 'depressive illness' and depressive disease'. The *disease* 'depression' may be universal, and identifiable in terms of biological and phenomenological criteria, whereas the subjective experience of depression, the *illness,* will vary considerably from culture to culture. The difficulties revealed in the interpretation of Mrs Xuyen's headache—arguably one of the most common human experiences—strongly support the value of observing such a distinction.

## Conclusion

All people become sick and require help, sometimes in the physical sense, sometimes emotionally and sometimes both. Every society provides a system of reference to explain the deviations of its members from good health. If the helper does not understand the system used by the patient or client, it becomes very difficult for him to match his intervention with what is sought by the person experiencing the disease. Vietnamese refugees, as a group, employ a broad range of concepts of health and illness: understanding these may increase the efficacy of the health care that we provide for them. The same applies equally to other patients from non-Western cultures.

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