Hwabyung: Symptoms and Diagnosis

Yong Chon Park, M.D., Ph.D.[1]

[1] Department of Neuropsychiatry, Hanyang University College of Medicine, Seoul, Korea

Correspondence: Yong Chon Park, M.D., Ph.D. Department of Neuropsychiatry. Hanyang University Guri Hospital, 249-1 Gyomoon-dong, Guri, Gyunggi-do, Korea (471-701)
Tel: +82-31-560-2273, Fax: +82-31-554-2599 E mail: hypyc@hanyang.ac.kr

Abstract

There are two points of views about Hwabyung-the longitudinal view and the cross sectional view. In the longitudinal view, Hwabyung is considered as a disease process, and the symptoms are interpreted dynamically. This view is based on the traditional meaning of Hwabyung. In the cross sectional view, Hwabyung is considered as a disease entity, with a focus on phenomenological understanding. This view attempts to categorize Hwabyung according to the diagnostic criteria of DSM, thereby enabling statistical analysis of this disorder and facilitating the communication of it's diagnosis and treatment betwe en different practitioners and researchers. Therefore, the longitudinal view considers the symptoms of Hwabyung to vary from mild physical and mental symptoms, including neurosis and somatization, to psychosis and death. In studies based on the cross sectional view, the symptoms of Hwabyung patients were statistically processed and it was found that hot or heat sensation, feeling oppressed, sensations of something pushing-up in the chest and epigastric mass are the four major symptoms, most of which are on the neurotic level of physical symptoms. In terms of the diagnosis, there are no objective diagnostic criteria in the longitudinal view, because all of the symptoms caused by anger are referred to as Hwabyung. In the cross sectional view, patien ts complaining of Hwabyung were diagnosed according to the DSM criteria, and somatization disorder, depression and anxiety were the most frequent diagnoses. The question as to whether Hwabyung is a culture bound syndrome or not remains controversial. Further research on this issue is needed in the future.

Key Words: Hwabyung, symptom, Diagnosis, Korea, Somatization, Depression, Anxiety Psychiatr Investig 2004;1(1):25-28

Introduction

There are two ways of looking at Hwabyung. The first one is the longitudinal view, which sees Hwabyung as the disease process according to the traditional meaning of the word "Hwabyung". From this longitudinal point of view, the term Hwabyung originated from folklore, wherein a patient suffered from a physical or mental unhealthy condition caused by accumulated and unresolved anger [1]. In this context, Hwabyung is not the name of the disease entity, but it is a dynamic explanation of the cause of the symptoms. The word "Hwabyung" is not listed in either the Chinese or Japanese dictionary, or even in the literature of herb medicine. In the literature of herb medicine, however, there are many diseases related to the accumulation of "Hwa", whose literal meaning is "fire". Bibliographically, "Hwa" has been used to refer to the symptoms rather than to the diagnostic disease entity itself. In herb medicine, Hwa is viewed through the Yin-Yang and Five Elements Theory, whose fundamental concept differs from the classification systems of Western medicines, such as DSM. The word "Hwabyung" has been handed down from ancient times, by people who see the mind and body as an integrated whole entity, whereas they are usually dichotomized by Western culture. In Asian cultures, the psychological state is expressed metaphorically by the physical state. In the past, it was mistakenly believed that somatization was associated with uncivilized cultures, however its existence has been generally accepted in Asian cultures. Just as using humor, one of the defense mechanism, Asian people can express feelings and thoughts without personal discomfort or immobilization, and without producing an unpleasant effect on others. They seem to favor the use of symbolic physical expressions; they express the physical terms verbally, but they know that the meanings are psychological ones. They seem to favor using double meanings. For example "Gahsumari" means heartburn, indicting a pain in the chest. However the other content of "Gahsumari" is psychological pain such as Hwabyung, which induces pain in the chest.

In examining Korean traditional culture, glimpses can be seen of deep psychological understandings of the human mind. The state of "A Woo Ta Gi", whose literal meaning is the state of suffering from the birth of a younger sibling, shows a certain understanding of the older sibling, who has been deprived of his or her mother, because of the birth of a younger sibling [2]. The older one becomes regressed and fails to thrive, and he or she becomes weaker and weaker. Spitz observed the same phenomenon and named it anaclitic depression. Another example is "Sang Sa Byung", which means love sickness. When a young man is deeply attached to a young woman, who remains beyond his reach, he becomes weaker and weaker, not responding to any form of medication, so that he may eventually die. This word is the name of the disease, but it nevertheless

also represents the whole dynamic process involved, including all of the various psychological and physical conditions, as in the case of the traditional meaning of Hwabyung.

The second way of looking at Hwabyung is the cross sectional view, which sees the Hwabyung from the view point of modern medicine, and which is different from the traditional culture oriented view mentioned above. In this approach, Hwabyung is interpreted using the concept of DSM, which categorizes the disease entity based on certain operational criteria. The most noteworthy characteristic of this view is that it attempts to consider Hwabyung as the name of one kind of disease entity. This approach may be appropriate given the recent tendency in psychiatry, where rapid diagnosis and standardized treatment method are the catchwords. Some dynamic psychiatrists show resistance toward these DSM style classifications; for example, the traditional meaning of "anxiety" differs from the "anxiety disorder" defined in DSM. The same is true for the relationship between "somatization" and "somatization disorder" in DSM. Gabbard also complained about the DSM nosology [3]. He stated that, "One unfortunate consequence of the deliberate effort to be atheoretical in the development of the DSM-IV nosology is the resulting sacrifice of classical neurotic entities and the psychodynamic model of symptom formation that is associated with them. It also encourages clinicians to think about anxiety as an illness, rather than as an overdetermined symptom of unconscious conflict." However, the advantage of this viewpoint is the convenience that it brings in terms of statistical research and improvements in the communication between clinicians and researchers, who use these standardized diagnostic criteria, such as the DSM categorization. In order to benefit from the above-mentioned advantages, current research on Hwabyung is being conducted based on a cross sectional viewpoints.

The term Hwabyung remains controversial because of the differing interpretations of this term that abound. However, if the term Hwabyung is included as part of a more complete term, for example, "Hwabyung" vs. "Hwabyung disorder" this confusion may be diminished.

Symptoms of Hwabyung

From the longitudinal point of view, the symptoms of Hwabyung are diverse and change with the passage of time, because they result from anger, which was accumulated without being resolved. Generally these symptoms vary from neurotic ones such as depression or anxiety to grave ones such as psychosis[4, 5]. The physical symptoms vary from somatization disorder to death [1, 5]. Lee [6] interviewed the neuropsychiatric out-patients with Hwabyung and divided the course of their symptoms into four stages. Stage 1 is the period of input. During this period, patient shows a panic response and destructive behavior under furious rage. A feeling of being betrayed, hostility, and murderous intent are the major emotions at this stage. Stage 2 is the period of conflict. During this period, the furious rage decreases and the patient falls into a deep inner struggle. It is during this stage that the patient enters into a typical state of anxiety. Stage 3 is the period of "chenyum" (giving up). During this period, the patient no longer tries to resolve the problem, but accepts the misery as his or her own. Often the patient projects toward the supernatural during this period, and the depressive symptoms become more prominent. Stage 4 is the period of somatization. During this period, somatic symptoms are the major complaints. Somatic symptoms develop in the form of a chronic stress response. At the same time, the depression improves.

Later, Lee explained that the processing mechanism of Hwabyung consists of two kinds of tempers, "Wool Ki" (heavy-temper) and "Hwa Ki"(heat-temper) [7]. In the shock stage, "Hwa Ki" is dominant with a prominent anxiety manifestation. Heat sensations are the base of the following symptoms; anger with passion, heat pushing-up in the chest, heat sensation during sleep and waking up suddenly, heart pounding nearly to the point of death and everything going black. The patient becomes anxious, agitated and feels a sensation of heat, accompanied by the impression that he or she is about to explode. In the giving up stage, "Wool Ki" is dominant with a prominent depressive manifestation. Stuffy and choking sensations are the base of the following symptoms; mass in the anterior chest, stuffiness in the chest, indigestion, frequent digestive upset, the inside seeming to be full of something and being struck dumb. The patient shows no interest in living and wants to die. The affect of the patient is inhibited and he or she looks calm outwardly. These two kinds of tempers are manifested either simultaneously or alternatively.

Rhi[8] connected Hwabyung with psychosomatic disorder. He argued that Hwabyung develops due to the severe and intense affect, so that medical disease and dermatological disease such as pruritus and hyperhidrosis can be caused by the emotional disturbance and conflicts. Although he did not mention these as being symptoms of Hwabyung, he cites various examples of the result of anger, such as assault on person, destruction of goods, drinking, taking pills for the purpose of committing suicide, suicidal car accidents, conversion symptoms and persecutory delusion.

From the cross sectional viewpoint, the symptoms of Hwabyung are identified mainly from the research findings pertaining to outpatients attending neuropsychiatric clinics. Min et al[9] studied neurotic patients and found that the somatic symptoms occur mainly in the head and chest, consisting of, headache, heat sensation on the body and face, palpitation, indigestion, the sensation of something pushing-up in the chest or of a mass in the throat and chest, dry mouth and dizziness. They reported such mental symptoms as depression, anxiety, sensitivity, irritability, nervousness, wanting to die, having no interest in living, no volition, a nihilistic mood, startling and loss of temper.

Min[10] found that the concept of "fire" is at the center of the symptoms of Hwabyung and proposed that the 4 cardinal symptoms of Hwabyung could be defined as hot or heat sensation, feeling oppressed, the sensation of something pushing-up in the chest and of an epigastric mass. Lee et al [11] studied the symptoms of neuropsychiatric out-patients from 7 clinics in rural and urban areas. In their study, the characteristic symptoms of the Hwabyung patients compared with those of the non-Hwabyung patients were as follows; indigestion, fatigue, flushing and chilling sensation of the body, cold sweat, dizziness, discomfort and pain over whole body, exhaustion, nihilistic mood, frequent startling, forgetfulness, loss of interest and over concern about incurable disease.

Min and Kim [12] analyzed the symptoms of Hwabyung using statistical methods. They summarized the symptoms according to the statistical significances. The most characteristic symptoms were as follows: chest stifling or oppression, impulse to go out, pushing-up sensation in the chest, weeping, cold sweat, remorse, pessimism, a sensation of mass in the throat and chest, insomnia and physical pain. The next most important common symptoms were rage, mortification, sorrow, bodily heat sensation, sighing, tension, depersonalization, dry mouth, tediousness, having many dreams, hate, feebleness and shame. They identified the typical symptoms, as well as other

symptoms, which could only be revealed by this systematic research. They anticipate finding the explanation for these symptoms by identifying specific biochemical activities in the central nervous system.

The other way of understanding the expression of symptoms is through the concept of cultural influences. The mechanism of change of psychological suffering into somatic symptoms can be explained through the understanding of cultural characteristics. Kim[13] described the four mechanisms of the cultural influences of somatization. First, a culture specific symbolic metaphor is a mediator in the expression of a symptom. Culture specific body language and body image acts as a mediator to change the psychological state in an indirect way rather than a direct way. The second mechanism is the traditional disease concept. In Korean culture, mind and body are not separated and every organ has a specific psychological function. For example, the heart is the place for mood and thought, while the liver is the place for bravery and the soul. In this way every emotional problem is expressed through the dysfunction of a particular organ. The third mechanism is the conventional way of adopting a given culture and society, that is through somatization. Conveying the opinion mediated through the somatic symptom is the way to maintain the social relationship and keep one's situation. In those cultures where direct expression of one's emotion is not regarded as desirable, conveying emotion through body language has the advantage of leading to secondary gain. Somatization is the weapon of the weak person. The fourth mechanism is associated with the medical system and milieu. The frequency of somatization symptoms varies depending on the utilization pathway of the medical system. When the medical service accepts physical diseases more readily, it is much more advantageous to express the physical symptoms rather than psychological symptoms.

Min[14] expected that the manifestations of Hwabyung might change from one generation to another. People in their sixties to seventies manifest the traditional features of Hwabyung in the form of somatization, through giving-up, pain and powerlessness rather than through the direct expression of anger. They seem to be influenced by the traditional social system and herb medicine. People in their forties and fifties, however, have a tendency to manifest the anger, psychological pain and physical phenomenon of anger directly. These seem to be influenced by the democratic culture, which encourages self-expression and freedom in this modern society. Min concluded that the clinical manifestation of Hwabyung might differ between generations.

Diagnosis of Hwabyung

One of the most difficult aspects in Hwabyung research is the diagnosis. Until now no approved diagnostic criteria for Hwabyung have been established. Each individual study of Hwabyung was conducted using diagnostic criteria, which were specific either to the patient or to the neighborhood in which he or she lived. To understand the personal disease process, longitudinal diagnosis is indispensable, but categorization of diagnosis from the longitudinal point of view is not feasible. For example, one interesting piece of anthropological fieldwork for the identification of Hwabyung involved a research survey carried out through participant observation [5]. In this study, the diagnostic criteria were formulated at the patient or neighborhood level, so that the reliability of the diagnosis was poor and replication of the study is difficult. The diagnosis of Hwabyung is so varied, ranging from mild to grave symptoms, that statistical study is impossible.

Min et al chose the cross sectional view to study the many aspects of Hwabyung. They studied the concepts [10, 15], symptoms[12], and diagnoses [16, 17], of Hwabyung, as well as performing clinical and epidemiological studies [9, 18, 19] and psychological studies [14, 20, 21]. To compare the results of their studies with DSM, Hwabyung can be diagnosed as somatization disorder, depression and anxiety disorder. A combined diagnosis rather than a single diagnosis is frequent [9, 17]. The combination of somatization and depression is the most frequent[10]. Lee et al[22] agreed that the coincidence of diagnosis of Hwabyung with the DSM-III diagnostic criteria is infrequent, so that a definite diagnosis based on the DSM criteria is unjustified and difficult to make. They also saw Hwabyung as a combination of several kinds of neurosis, rather than a single neurotic diagnosis. Differences in the diagnosis are also observed according to the culture and area. Lin [23] and Lin et al [24] conducted research on Korean American immigrants with Hwabyung living in the U.S.A, and found that depression is the major contributing factor.

On the other hand, in Oriental medicine, Kim [25] insisted that the currently used term, "Hwabyung", is obviously different from the one that Oriental medicine deals with bibliographically, and he is currently in the process of establishing a new DSM type diagnostic standard.

Discussion

The reason for Hwabyung being defined as a culture bound syndrome according to DSM-IV might be that patients from different cultures were encountered in clinical practice in North America, because interest in the cultural framework of illness, diagnosis and care has been stimulated by increasing awareness of cultural diversity in U.S. society[26]. Korean immigration to the U.S.A has a 100 years history and the number of immigrants from Korea living in the U.S.A is increasing. Some psychiatrists[27, 28], transcultural researchers [29], and herb doctors [30] do not agree that Hwabyung is a culture bound syndrome, and there has not been enough researches carried out on this issue.

Research on Hwabyung is important for various reasons. As in the case of "taijin kyofusho", which was once considered as a syndrome peculiar to Japan before turning out to be prevalent in western society. Likewise, research on Hwabyung will contribute to the research on unidentified psychopathologies in other cultures. Before Lin [23] introduced the term Hwabyung to the international academic community, Lee [6] described Hwabyung as a kind of anger syndrome, which is the end result of unexpressed anger, whatever the cause maybe. Min and Kim[12] said that Hwabyung is a typical cause of the chronified syndrome of anger attacks. Min [14] suggested renaming Hwabyung as "anger disorder". Because there is some controversies surrounding the definition of the term Hwabyung, the idea of describing such patients as suffering from anger and other related symptoms seem appropriate. Intensive research and transcultural research need to be conducted on this issue.

Summary

While integrating the different studies on Hwabyung, I found that there were two ways of looking at this disorder, namely from the longitudinal view and the cross sectional view. In the longitudinal view, the symptoms of Hwabyung are considered to span a broad spectrum, from mild neurosis and somatization

disorder to psychosis and death, because this view is based on a traditional concept that regards Hwabyung not as the name of a disease, but as a disease process. In the cross sectional view, Hwabyung is considered as a single disease entity, following the diagnostic criteria of DSM. Neurotic symptoms were mainly reported by Min et al, because they conducted research on outpatients, and identified four major symptoms of Hwabyung, namely-hot or heat sensation, feeling oppressed, sensations of something pushing-up in the chest and epigastric mass. Compared with the DSM diagnosis, they found that Hwabyung is generally accompanied by a combined state of depression, somatization and anxiety. Also, they introduced the new diagnostic term, anger disorder, in order to avoid the confusion associated with the existing term. Although there are still some controversies surrounding the name of culture bound syndrome, it is certain that research on Hwabyung will contribute to the development of psychiatry in the future.

References

1. Rhee DS: Hwabyung study-attitude of study. Dae Hwa 1986; 3: 65-68.
2. Rhee DS: Understanding and treatment of neurosis. Seoul, IlJiSa; 1993.
3. Gabbard GO: Psychodynamic Psychiatry in Clinical Practice, Third Edition. Washington DC, American Psychiatric Press; 2000.
4. Kim YS, Cho SC, Kim E Chung KC, Oh S, Choe TS, Cho DY, Rhi BY, Lee CK: The attitudes, knowledge and opinion about the mental disorders in the rural Koreans-a sociopsychiatric study of rural society in Korea (II). J Korean Neuropsychiatr Assoc 1975; 14(4): 365-375.
5. Kim JK: The belief and practice in Korean folk medicine-A case study on Hwa-byung- [Thesis of master]. Tae Gu: Kyungpook Univ: 1994.
6. Lee SH: A study on the "Hwa-Byung" (Anger syndrome). J Korea Gen Hosp 1977; 1(2): 63-69.
7. Lee SH Cho SY, Lee SH: Processing mechanism of "Hwa-Byung" as the Wool-Wha disease. J Koryo Gen Hops 1989; 12: 151-156.
8. Rhi BY: Hwa-byung and letting off steam. HyupDong 1969; 98-101.
9. Min SK, Lee MH, Kang HJ Lee HY: A clinical study of Hwabyung. J Korean Med Assoc 1987; 30(2): 187-197.
10. Min SK: A study of concept of Hwabyung. J Korean Neuropsychiatr Assoc 1989; 28(4): 604-616.
11. Lee C, Lee CH, Hong JP, Kim SY, Kim CY, Park IH, Han OS: A comparative study on illness-concept of Hwa-byung between the Hwa-byung experienced group and the inexperienced group. The Ulsan Univ Med J 1995; 4: 45-54.
12. Min SK, Kim KH: Symptoms of Hwahyung. J Korean Neuropsychiatr Assoc 1998; 37(6): 1138-1145.
13. Kim KI: Culture and somatization. Korean J Psychosomatic Medicine 2003; 11(1): 3-14.
14. Min SK: Cultural relatedness of Hwabyung and beyond. Behavioral Science in Medicine 2004; 3(1): 97-102.
15. Min SK, Soh EH, Pyohn YW: The concept of Hwabyung of Korean psychiatrists and herb physicians. J Korean Neuropsychiatr Assoc 1989; 28(1): 146-154.
16. Park JH, Min SK, Lee MH: A study on the diagnosis of Hwabyung. J Korean Neuropsychiatr Assoc 1997; 36(3): 496-502.
17. Min SK, Lee MH, Shin JH, Park MH, Kim MK, Lee HY: A diagnostic study on Hwabyung. J Korean Med Assoc 1986; 29(6): 653-661.
18. Min SK, Namkoong K, Lee HY: An epidemiological study on Hwabyung. J Korean Neuropsychiatr Assoc 1990; 29(4): 867-874.
19. Min SK, Kim JH: A study on Hwabyung in Bokil Island. J Korean Neuropsychiatr Assoc 1986; 25(3): 459-466.
20. Min SK, Park CS, Han JO: Defense mechanism and coping strategies in Hwabyung. J Korean Neuropsychiatr Assoc 1993; 32(4): 506-516.
21. Min SK: Hwabyung and the psychology of Hahn. J Korean Med Assoc 1991; 34(11): 1189-1198.
22. Lee SH, Oh KS, Cho SY, Bae SJ, Lee SH, Kim YC: A clinical study of "Hwa-Byung" (II) - "Hwa-Byung" as the reaction of anger. J Koryo Gen Hosp 1989; 12: 145-150.
23. Lin KM. Hwa-Byung: A Korean culture-bound syndrome? Am J Psychiatry 1983; 140(1): 105-107.
24. Lin KM, Lau JC, Yamamoto J, Zheng YP, Kim HS, Cho KH et al: Hwa-Byung A community study of Korean Americans. J Nerv Ment Dis 1992; 180(6): 386-391.
25. Kim JW: Hwabyung in Oriental medicine. Behavioral Science in Medicine 2004; 3(1): 103-107.
26. Mezzich JE, Kirmayer LJ, Kleinman A, Fabrega H Parron D, Good BJ et al: The place of culture in DSM-IV. J Nerv Ment Dis 1999; 187(8): 457-464.
27. Rhi BY: Hwabyung-An Overview. Psychiatr Invest 2004; in pressing.
28. Chang SC: Letters to the editor. Am J Psychiatry 1983; 140 (9): 1268.
29. Prince R: Somatic complaint syndromes and depression: The problem of cultural effects on symptomatology. Mental Health Research 1989; 8: 104-117.
30. Ku BS, Kim DI: A study of Hwabyung, its review and prospect. Dongguk Journal: Natural Science 1997; 36: 265-283.