Depression and Culture—A Chinese Perspective

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Abstract

This paper reviews the current cross-cultural studies on depression among Chinese people. Compared with the Western world, diagnosis rates are very low in depression and high in neurasthenia in China. It is stressed that somatic complaints are much more common and more culturally acceptable than affective expressions among Chinese clients. Discussed in this paper are the following factors contributing to such tendencies: (a) traditional Chinese medicine, (b) social and political norms, and (c) language use relating to emotional expression. Counselling implications, such as the use of symbols, relabelling, and the way of approaching Chinese clients, are addressed in light of cultural sensitivity and knowledge for counsellors in cross-cultural settings.

Résumé

Cet article passe en revue les études de counseling interculturel de dépression parmi les personnes de race chinoise. Comparé au monde occidental le taux de diagnostique de dépression est plus bas et le taux de neurasthénie est plus élevé en Chine. Il est mis en évidence que les maladies somatiques sont beaucoup plus courantes et plus acceptables que les expressions affectives parmi les clients chinois. Cet article décrit les facteurs suivants contribuant à ces tendances: (a) la médecine chinoise traditionnelle; (b) les normes socio-politiques; et (c) l'usage de language en rapport avec l'expression émotionnelle. Les implications pour le counseling tel que l'usage des symboles, la ré-identification, et la façon dont les clients chinois sont approchés, sont considérés à partir d'une perspective culturelle et de la connaissance des conseillers opérant dans un milieu interculturel.

The basic symptoms of major depression, according to DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, 1994), are composed of affective traits (sadness and weeping), cognitive style (low self-esteem, pessimism and a sense of meaninglessness), and the vegetative substratum (sleep disturbance and weight loss). More specific symptoms such as self-neglect, loss of appetite and sexual interest are also considered in this diagnosis. The basic symptoms are almost universally chosen as the core of depressive disorders, but the more specific symptoms vary from culture to culture (Al-Issa, 1982; Draguns, 1989; Nikelly, 1988).

Recently, investigators have begun paying attention to the relationship between Chinese culture and psychiatric disorders (Jenkins, Kleinman & Good, 1991). Several studies have found that the depression diagnosis rate is very low in the People's Republic of China, where neurasthenia diagnosis (which is no longer used in DSM-IV) is still in use (Cheung, 1982, 1984; Kleinman, 1986; Yeh, 1987). In China, neurasthenia is considered a common sickness. In addition to being related to an inherited neurotic trait, neurasthenia is a form of psychiatric disorder caused by stress from the environment. Also, hysteria, obsessive disorders, phobias,

anxiety disorders, and hypochondriasis are all included in the description of neurasthenia. Whenever a person suffers from insomnia, dizziness, headache, poor concentration and related complaints, and as long as the symptoms are not serious enough, the person is diagnosed as neurasthenic (Yan, 1985). It is commonly observed among Chinese patients that somatic complaints are more prominent (Kleinman, 1979; Tseng, 1975), and that the affective mode of expressions seldom appear (Chang, 1985). A variety of social, cultural, religious, and educational factors may exert some influence that shapes the affective disorder (Mendels, 1970). These characteristics vary in Chinese culture because depression is conceptualized, identified and interpreted in various ways (Cheung, 1982; Nikelly, 1988).

Many cultural factors are involved in depression, and some play extremely important roles in China. Among those, three factors are discussed in this article: (a) traditional medicine and depression; (b) social political influence and the diagnoses of neurasthenia; and (c) emotional expression and somatic symptoms.

Traditional Chinese Medicine and Depression

Traditional Chinese medicine has been used in China for thousands of years. Almost every Chinese person has experienced traditional methods of treatment, and many prefer it to Western medicine. Traditional medicine theory associates health with emotional balance, and mental illness with emotional excess. According to this theory, depression is divided into three subtypes: (a) *nuyu*: depression resulting from excessive anger; (b) *siyu*: depression resulting for excessive thinking; and (c) *yoyu*: depression resulting from excessive worry.

The very common disorders regarding the similar symptoms of depression in the classical diagnosis, such as *shen-kui* (kidney deficiency syndrome) and *xie-ping* (devil's sickness) are considered culturally related syndromes. According to traditional Chinese medicine, *shen* (kidney) controls the function of the cerebrum. Thus, *shen-xu* causes a range of hypochondriac preoccupations including blurring of vision, cold sweats, palpitations, and alleged discoloration of urine. The symptoms like dizziness, tints, insomnia, fatigue and spermatorrhoea are caused by *shen-yang* (positive element of the kidney).

Depressive disorder rates in China are either under-reported or extremely low. For example, during a one-week period, 361 patients visited the psychiatric outpatient clinic at the Human Medical College; 30% were diagnosed as neurasthenic and only 1% were diagnosed as depressed (Kleinman, 1986). Obviously, one of the reasons for the low rates is that the patients cannot be listed under the diagnosis of depression. If the patient visited a traditional doctor, the patient will be diagnosed as *shen-kui* or *xie-ping*, but not as depressed. Bermann and Mendels (1968)

pointed out that another reason for the low rate of depression among Chinese patients was that many of them were classified as neurasthenic.

Social Political Influence and Neurasthenia

Generally speaking, neurasthenia is rendered as *shenjing shuairuo* for Chinese people, this literally means neurological (*shenjing*) weakness (*shuairuo*). The chief symptoms consist of dizziness, bitter taste, loose stools, insomnia, frequent dreams, reduced appetite, weakness, spermatorrhoea, amnesia, chest discomfort, hypochondriac pain, anxiety and a variety of other complaints, which are often listed in the vegetative substratum of depression in Western diagnosis.

Kleinman (1986) entertained the possibility that Chiense patients actively reject the psychiatric label of depression and reaffirm the organic medical label of neurasthenia. This may be a consequence of political influence. The concept of only "Counter-revolutionaries are unhappy" has long affected Chinese people, especially in the People's Republic of China. Thus, emotional distresses such as depression were often painted with a strong political colour. Psychology itself was very much banned between 1949 and 1980 (Li, 1993), because it was considered to be against "correct" political thinking. During the Chinese cultural revolution, for example, all mental illnesses, and most notably depression, were called into question by the Maoists as wrong political thinking. This political meaning still seems to affect the attitude towards depression.

Emotional Expression and Somatic Symptoms

Neurasthenia frequently occurs in Chinese cultures, because the bodily complaints are a socially sanctioned medium of communication of personal distress. Some researchers have noted that Chinese patients have fewer complaints of emotional conflicts and tend to express their emotional disturbance through somatic symptoms (Kleinman, 1988; Tseng, 1975). For example, during Tseng's (1975) first visit to Taiwan, he reported that nearly 70% of the psychiatric outpatients presented somatic complaints. Explanations for this phenomenon include: (a) somatization when the patient experiences only the physical symptoms while the psychological problems are repressed; (b) somatic presentation when the patient is aware of the psychological symptoms, but instead chooses to present somatic components of the psychological symptoms in the help-seeking processes (Cheung, Lau & Waldmann, 1980); and (c) somatic symbolism when used as a metaphor to describe and/or to understand psychological problems.

Generally, in China, bodily complaints are a socially accepted medium of communication of personal distress in China. Overt expression of affection and discussion of psychological issues are discouraged in Chi-

nese culture. Help-seeking is legitimated for bodily complaints but not for psychological complaints. Physical complaints have social cachet, whereas psychological complaints do not. The psychological aspects of depression may be experienced and even shared with a few trusted friends, but such psychological distress may be an inappropriate signal for clients initiating their action for seeking help from health professions (Tseng & Wu, 1985).

Emotion in traditional Chinese literature is portrayed subtly and indirectly via body movements, dress, environmental description and allusive language, but not by direct verbal expression. Usually, direct verbal expression of emotion is regarded as insensitive and uncouth. Investigations have shown that a relationship exists between deficits in expression of affect and psychosomatic symptoms (Anderson, 1981). Somatized presentations and behaviours are created by blocked expression of emotion while simultaneously sanctioning and nurturing somatic preoccupation.

Verbal expressions of emotions in the Chinese language are still predominantly somatically oriented. Even though there are written Chinese characters designating states of depression, there are no equivalent expressions in the spoken language. The closest to such an expression is *xin qing bu hao.* It means that the condition of my heart is not good, implies that one is in a bad mood. Studies have shown that many emotional expressions in the Chinese language fail to make a clear distinction between physical symptoms and psychological distress (Kwong & Wong, 1981).

Cheung and her colleagues (1980) suggested different psychological causes of somatization as a manifestation of depression. The authors interpreted that "a somatic façade" concealed the depressed patient's admission of feelings of sadness. Depressed Chinese patients may not be aware of the experience of sadness simply as a salient symptom. Even when they are aware of dysphoria, clients may suppress and disguise their depressed feelings due to the fear of the powerful social stigma attributed to mental illness. Hence, multiple physical complaints serve as a culturally sanctioned avenue for expressing depressive reactions.

Some Suggestions for Counselling

Since the demand of cross-cultural counselling is increasing in recent years, how to work with Chinese clients may concern counsellors in a multicultural setting such as Canada (Atkinson, Thompson & Grant, 1993; Sue & Zane, 1987). Because the strong influence of traditional Chinese customs, many Chinese people in Canada are often concerned about not making direct statements to others, and are worried about "losing face" for themselves and their families. Therefore, it is not surprising that clients are very careful about what and how they reveal to

counsellors, and that they have difficulty opening up to "strangers" or "outsiders" (Cheung, 1984; Jenkins, 1988). These difficulties seem even more intense for depressed clients. Because the fields of psychology and counselling are relatively new in China, especially in the People's Republic of China, very few Chinese have the experience of receiving counselling (Li, 1993). Therefore, they may feel increased anxiety due to the unfamiliarity with the concept of counselling.

Helping depressed Chinese clients is the same as helping any population in a cross-cultural setting. Understanding expressions and communicating with clients about their experiences are very important in the process of success (Jenkins, Kleinman & Good, 1991). Counsellors need to be aware of the beliefs, diagnoses and techniques used in the cross-cultural environment.

In considering clinical practice, the use of symbols and relabelling may be beneficial in working with Chinese clients. Symbols, such as objects, gestures, and physical signs, can be viewed as indirect ways of presenting personal needs and meanings as well as emotions. Asking Chinese clients to bring their favourite pictures to the session, for example, can change the focus from the person to the objects (Ishiyama & Westwood, 1992). By using external objects and metaphors, clients may be helped to lower the anxiety that they may feel during counselling, and at the same time convey their personal messages to the helpers. By choosing and talking about the objects that they are familiar with, clients may also be helped to overcome possible language barriers in a cross-cultural helping interaction (Westwood & Ishiyama, 1990).

In addition to the use of symbols, relabelling techniques can be applicable and effective in working with Chinese clients. Instead of using the label of depression, the counsellor may use other expressions such as neurasthenia or *xin qing bu hao*, especially to the clients who come from the People's Republic of China. With this technique, the helpers capitalize on the pragmatics of Western culture by using the concepts with which their clients are familiar. By doing so, counsellors can not only help clients understand their distress, but also alleviate the stigma-related anxiety in presenting their problems.

Moreover, borrowing or applying the Chinese traditional medicine theory on depression in working with Chinese clients is highly recommended. Counselling will be more acceptable and effective if it can assist clients to talk about the contents of their excessive anger, worry, and thinking. The focus should be on helping Chinese clients to express their distress in a way that they can maintain face by not talking about their emotions. In terms of practice, questions like: "What did you do?" is preferable to "How do you feel?" Similar to Morita therapy (Ishiyama, 1987, 1990), experiencing psychoeducation and challenge are acceptable by most Chinese clients. Therefore, Canadian counsellors should

feel open and respectful towards cultural differences, and at the same time willing to listen to and share opinions with Chinese clients.

Conclusion

The question of how to counsel people from different cultures has attracted much attention in the field of counselling (Pedersen, 1993). It is necessary to be sensitive to the influence of Chinese traditional medicine, social political issues related to neurasthenia, and the use of somatic complaints on the expressions of distress among Chinese clients. It is hoped that this review of Chinese perspective on depression will provide a useful profile to cross-cultural counsellors.

Cultural differences in how depression is experienced and presented may cause some difficulties in counselling. However, understanding this problem from different cultural settings can nevertheless broaden our perspectives in this field. Hopefully, the Chinese perspective presented in this paper will help to create a bridge in linking studies of culture with investigations and counselling of depressed clients. As Sartorius (1987) concluded, cross-cultural research could result in helping to resolve the conundrum of depression and respond to the challenge that depression poses to society.

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