Some recommendations to assess depression in Chinese people in Australasia

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Objective: To provide some general recommendations for psychiatric assessment of depression among Chinese patients within a predominately Western society.

Method: A literature review is provided with interpretive comments.

Results: The prevalence of depression reported in community studies undertaken in Chinese communities is very low. To what extent Chinese people experience and seek help for depression, and how they report depressive symptoms have long been topics of some importance. The impact of acculturation as well as concepts and interpretations of illness in traditional Chinese medicine are discussed. Awareness of sensitive issues and practices within the Chinese culture will facilitate communication between medical professionals and patients, resulting in more accurate identification and diagnosis of depressive disorders.

Conclusion: Direct but culturally sensitive and empathic questioning of psychological symptoms is needed to unveil patients’ explanatory models, as most Chinese initially nominate only somatic symptoms to health practitioners. Successfully treated patients can promote earlier and wider utilization of mental health services to other Chinese people.

Key words: assessment, Chinese, culture, depression.

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There are over half a million Chinese individuals living in Australia (approximately 3% of the Australian population [1]), and with the Chinese ranking fifth after English, Irish, Italian and German among the major ethnic groups. A recent audit [2] established that 400,000 people (i.e. 2.1% of the Australian population) are primarily Chinese speaking. The extent to which Chinese individuals experience and seek help for depression, and the ways in which they directly or indirectly report depressive symptoms have important clinical implications. We suggest that there is now sufficient information to allow a set of recommendations for Australasian psychiatrists who assess and manage Chinese patients. This paper is one of several being developed by the Black Dog Institute, reflecting its charter [3] to assist clinical assessment and management of mood disorders.

Who are the Chinese?

As previously detailed [4], the Chinese are the world’s largest ethnic group, representing nearly one-quarter of the world’s population. They are nevertheless distinctly heterogeneous, with more than 50 officially described ethnic groupings in mainland China alone, where there are multiple dialects, and where multiple socio-cultural changes have occurred over a relatively short period. The Chinese in Australasia range from individuals whose families have been established for many generations through to recent immigrants. Immigrants may have come from China, from other Asian countries or...
from Western regions, from westernized, urbanized and industrialized regions, or from rural towns or villages. They may be highly educated or illiterate, and they may have migrated freely or come as refugees or as victims of trauma.

One issue common to these Chinese-Australians is the experience of ‘acculturation’, albeit expressed to various degrees. Berry and Sam [5] cited an early definition of the acculturation process: ‘phenomena which result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original culture patterns of either or both groups’ (p. 293). They put forward four major ‘acculturation strategies’ commonly employed by ethnic groups: ‘assimilation’ (rejection of the native group and identification with the target group); ‘separation’ (rejection of both cultures as ethnic reference groups and identification with both the native group and the target group); ‘integration’ (identification with both the native group and the target group); ‘adjustment’ (rejection of the target group and identification with the native group); and ‘marginalization’ (rejection of both cultures as ethnic reference groups, albeit to varying degrees). Recently, Ryder et al. [6] proposed a ‘bi-dimentional model of acculturation’, arguing that people exposed to two cultures can incorporate, either through birth or through heritage, two coexisting cultural self-identities (i.e. the old cultural identity does not necessarily diminish while the new one grows). In this article we assume that total assimilation is rare, and therefore seek to define key Chinese cultural and family characteristics that may influence illness expression and help-seeking patterns, and other issues that may impact on the assessment and management of a depressed Chinese individual.

How do the Chinese experience depression?

It is commonly held that the Chinese tend to deny depression or express it somatically, thus generating very low rates in community studies. For instance, our earlier review [4] noted the rarity of depression being commented on by western observers visiting China in the 1980s, a 1993 community survey in China quantifying a 0.08% lifetime depression rate, distinctly lower rates in several Taiwan community studies and lower rates (than US comparative data) for Chinese Americans living in Los Angeles. That review suggested four factors. First, symptom reporting may be restricted by stigma, political influences, ‘weakness of character implications’ and the Chinese view that emotional illness is part of ‘life’. Second, idiomatic reporting of illness and distress, reflecting the Chinese epistemology of disease, a language of emotions underpinned by metaphors and physical symbols – and with the somatic conduit enhanced by the cultural popularity of concepts such as neurasthenia and ‘shenjing shuairuo’ (SJSR). ‘Shenjing shuairuo’ translates as weakness of the body channels carrying ‘qi’ or vital energy, and, as for neurasthenia historically, allowed a non-stigmatizing socially acceptable mantle to be developed that was distant from psychiatric labelling and its consequences. Third, the lack of appropriate case-finding tools makes detection more difficult, particularly when the Chinese may apply a higher threshold for labelling responses to life’s stressors as pathological. Fourth, socio-cultural and family values, such as quiescence and stoicism, as well as family support, may both assist as coping repertoires to prevent and minimize depression, as well as influence help-seeking and reporting. Such multiple factors thus allow that the Chinese may have both a true low incidence of depression ‘caseness’ and also under-report true episodes.

It remains unestablished empirically whether acculturation attenuates or nullifies all such factors, as few studies of Westernized Chinese have been undertaken. Takeuchi et al. [7] reported a community study of 1747 Chinese Americans living in Los Angeles. While their lifetime rate of major depression was one-third of the rate established in the US general population, rates of dysthymia were very similar. This study failed to show a significant effect of seemingly direct acculturation markers (such as English language skills and length of residence in the US) on depression rates, and could thus be interpreted as suggesting that Westernized Chinese retain some cultural ‘protection’ against major depression. However, in those rated as highly acculturated, the women were more than twice as likely to men to have a lifetime depressive episode (similar to the gender pattern in most Western developed countries). In Takeuchi’s low acculturation subset, there was no gender difference in depression: men were as likely to suffer depression as women. While the impact of acculturation on gender is capable of multiple interpretations, the point of note is that the apparent protective factors for men are diminished. Thus, a major acculturation influence is demonstrated in this study.

Furnham and Li [8] studied psychological adjustment and depression symptoms in two generations of Chinese in Britain, with age being established as a crucial factor. Among the first generation group (aged 19–60, who migrated at or after 18 years of age), the younger the individual, the more likely they were to report both psychological symptoms and a poor sense of belonging to the host community. The second generation group (aged 18–30, either born in Britain or who left Hong Kong before the age of 10), and who reported a good sense of belonging with the host community were, in contrast, more likely to report psychological symptoms. The age at study for these two subgroups was very
similar, but their age at migration was quite different. It would appear that being brought up in Western cultural environment is associated with a greater psychologizing of symptoms (rather than following a Chinese culturally sanctioned somatization path). Further, age at migration may be more important than age at study in terms of acculturation effects.

In terms of somatization – where the term is used here to describe a culturally accepted way of expressing ‘discomfort’ – a recent study challenges the view that the Chinese necessarily somatize. Yen et al. [9] compared somatization scores on the CES-D depression scale, for: (i) Chinese university students in China; (ii) Chinese-American college students; and (iii) their Caucasian-American counterparts, with the Chinese students returning lower somatic scores than those in the two other groups.

One study [10] of Chinese American College students reported that Chinese migrants who left their home country at a very young age more closely follow the pattern of non-migrants brought up in a Western culture. Thus, somatization in the Chinese may be quite dependent on cultural and acculturation influences, and even independent of race. We also need to distinguish between somatization of distress as experienced by the individual and as reported to others, including family members and health practitioners. In regard to the last, our earlier review [4] allowed the conclusion that presentation of somatic symptoms to a practitioner may be an initial negotiating technique only and that the ‘truly depressed patient may be expected to admit to depressive symptoms when the interviewer moves beyond open-ended questions to more specific questioning.’

The following overview therefore focuses on the assessment of depression in Chinese people in Australasia with a distinct Chinese cultural base and who may or may not have been integrated into the Australasian culture.

**Awareness of cultural-sensitive issues and cultural practice: the need to reflect the patient’s explanatory model**

Cultural factors promote social cohesion. For the Chinese, this is effected across a variety of parameters. Understanding of these nuances allows an explanatory model [11] to be shaped for the individual patient. Six examples are now noted.

**Ancestor worship**

Many Chinese nowadays still hold a strong belief that ‘misfortune’ can be the curse of an ancestor or a demon process incurred by ‘misconduct’.

**Filial piety**

This major goal to always remember one’s roots guides the socialization of children growing up in a Chinese culture [12], although King [13] contends that filial piety is not necessarily treasured for its intrinsic goodness but preserved more for its extrinsic usefulness in pursuing economic goals.

**Socio-centricity**

Chinese society is socio-centric with the wellbeing of the community as a whole taking precedence over the individual’s desires.

**Taoism**

Echoing Lao-Tsu (600 BC), ‘all life is impermanent’ is an important cultural construct defined as Tao (which literally means ‘the Way’), the ultimate reality of the universe and human life. He held that the world is composed of opposing energy sources yin and yang. As a consequence, the best way to deal with life is wu-wei, letting things take their own course [14]. The capacity to accept such a philosophy has important cultural implications. Helman [15] has suggested that one of the possible explanations for the lower rates of mental illness among the Chinese (as well as Italians and Indians) is their great determination to migrate (for a better future for the next generation). However, he also postulates that many Chinese migrants do so for economic reasons, to effect a high degree of entrepreneurial activity, without making any major attempt at assimilation, as their intention is to return ‘home’ one day. For such individuals, cultural values would be expected to be strong and sustaining.

**Repression of emotion**

This is a long-standing tradition, and a marker of correct social behaviour, with emotional expression being stigmatized [16]. The Chinese culture as for others, modifies how one publicly expresses or privately suppresses emotions to live up to the expected cultural standards [17].

**The illness model**

The Western medicine concept of mental illness is based strongly on the Cartesian dichotomy of mind and body, with psychiatrists being medically trained specialists treating clinically abnormal ‘minds’. By contrast, the ancient Chinese yin/yang cosmology represents a complementary balance between the two forces or energies.
The entire cosmos is believed to be in a state of dynamic equilibrium, with the human body likewise being understood as moving between *yin/yang* forces. An individual’s wellbeing is upset if the equilibrium is displaced.

The *yin/yang* cosmology explains the Chinese belief in using traditional Chinese herbal remedies to restore harmony between the individual and his environment. Unschuld [18] points out that Chinese medicine strongly stresses that the ontological cause of disease – with the individual as part of his environment – is subject to change in his immediate physical surroundings. By attributing an ‘external cause’ to the ‘distress’, be it somatic discomfort or loss of social-environmental equilibrium, the patient is relieved of responsibility for the ‘illness’, minimizing morally assigned shame and guilt.

Ways to restore *yin/yang* harmony include taking Chinese herbal medicine to balance the vital organs, or by treating the *Feng Shui* of the surroundings (location of residence and ancestors’ graves, etc.). In Western psychological terminology, traditional Chinese herbalists or *Feng Shui* masters act like counsellors, listening to the patient’s somatic and non-somatic accounts of distress, and working out possible solutions that fit well with the patient’s own cognitive beliefs. We provide some background on these issues.

Most Chinese use some form of Chinese herbal remedies for minor ailments, with such medicines passed down from generation to generation. The wide recognition of the connection between illness, food and drink can be traced back to the 7th century BC. Incorporating traditional beliefs, Ho, a physician of the *Chin* State (circa 400 BC) expounded that: ‘An excess of *yin* (influences) leads to cold-illness. An excess of *yang* (influences) leads to heat illnesses. An excess of darkness leads to emotional illnesses. An excess of light leads to an affliction of the heart’ [19]. Most Chinese will categorize their daily food according to its ‘*heat*’ and ‘*cold*’ nature. ‘*Hot*’ (heat-related) food will usually raise the ‘*fire*’ element of the body (e.g. very spicy food); to balance it one has to eat some ‘*cold food*’ (e.g. drink Chinese green tea after a big meal). Such beliefs stem from the concept of depletion (*hsu*) and repletion (*shih*) in the body’s five depots (heart, liver, spleen, lung and kidney) as well as the obstructions in the transportation channels (*ching*). Thus, to the Chinese, diseases are primarily a result of inability – or willful negligence – of man to adapt his behaviour to the *yin/yang* and other influences of his environment.

Around the 2nd century BC, the book thought to be the first summary of traditional Chinese medicine in antiquity described some important nuances. For example, *Huangdi-Neijing-suwen*, mentioned ‘wind’ (*feng*) as the cause of various diseases. *Xin-feng* (wind-heart disease) was employed to signify a patient whose heart had been affected by the wind in the height of summer [20] explaining why Chinese turn to a *Feng-Shui* master (literally means master of wind and water) for almost anything (e.g. to re-arrange household furniture; to cure a chronic illness). Unschuld [18] claims this ‘unscientific’ component of Chinese medicine offers ‘psychotherapeutic’ services that were apparently unavailable through the systematic correspondence approach. The Chinese are also very keen to ‘preserve life’ (*yang-sheng*) by achieving a balance in the influence of the body, by avoiding excessive deficiencies or surpluses in cold and heat, hunger and surfeit, lusts, desires and emotions.

Thus, the first step for psychiatrists treating Chinese people is to listen to and respect the patient’s own interpretations of the illness.

**Experience of depression in Chinese people**

After obtaining the patient’s ‘explanatory model’, the next step should generally involve the direct assessment of the patient’s symptoms and illness experiences. As shown in a comparison study of Australian and Malaysian Chinese depressed patients [21], Chinese patients were more likely to prioritize bodily a ‘health problem’ (particular aches and pains) rather than nominate psychological features as presenting symptoms. However, when a list of differing psychological and somatic features was rated in this study, both groups rated insomnia, thinking too much, guilt and anxiety as common features. Again, there is a need for the clinician to distinguish nominated somatic problems from illness-specific features.

The workload of many doctors and psychiatrists in Chinese regions is often insufficiently appreciated as a contributing issue to detection. Cheung [22] notes that the heavy caseload of general practitioners in Hong Kong leaves them with very little time to discuss a patient’s psychological concerns, thus seemingly reinforcing a somatic focus.

Thus, culture is more likely to influence the nomination of symptoms to a health practitioner rather than shape or distort integral illness patterns, with Lee [23] arguing that ‘Somatization in the Chinese context is rarely an unconscious denial of “underlying” affective and psychopathological states’ (p. 452). To the Chinese, physical or ‘bodily’ symptoms are more salient than psychological constructs. This is not surprising if we examine Chinese idioms, where bodily metaphors are the norm [24].

Nevertheless, and as noted, direct questioning of psychological symptoms and psychological explanations...
is likely to produce salient information in Chinese patients. As an example, Cheung and Lin [25] described a 28-year-old Chinese-Vietnamese female patient who migrated to America for a family reunion. After experiencing persistent headaches and soreness of the eyes, she consulted a Vietnamese psychiatrist who gave her a diagnosis of ‘neurasthenia’. When referred to the authors, she articulated her distress in ‘psychological’ terms and related her emotional stress to the major changes in her life. Further, Ying [26] studied Chinese-American women and reported that while few Chinese migrants attributed their distress from emotional sources, they were able to provide a ‘psychological’ explanation model when asked to nominate the major cause of their problem.

Yen and colleagues [9] undertook a cross-cultural study of manifested depressive symptoms in China and the US, observing that: ‘Chinese patients experiencing depression would initially report to their primary care physician with somatic symptoms but would report affective symptoms if directly assessed’ (p. 998). They argued, from this, for a ‘direct assessment’ approach, but also recommended that health professionals provide psycho-education to encourage Chinese patients to verbalize their symptoms in a non-somatic way. We suggest that such nuances hold in Australasian Chinese.

**Family members’ response to diagnosis of depression**

Family members usually will show their concern and support for a depressed member in a culturally appropriate way. Helman describes families as large cultural groups that may have their own particular world view, and their own myths and rituals [15]. Some senior members of the family may act as mediators for relationship disputes for the junior members. There exists a well-structured hierarchy of power within Chinese families with ways for family members to communicate psychological distress to one another and to the outside world. Family members who believe in self-control may, nevertheless, encourage the individual to ‘pull yourself together’ in adversity.

The traditional Chinese family usually works as a whole unit in the healing process, thus often explaining the reluctance of many Chinese patients to disclose details of emotional states to Western doctors, who are seen as specializing in treating physical symptoms. Most Chinese will only confide what they perceive as ‘private’ matters to their family members or their closest friends. There is the well-known Chinese idiom: ‘Report the good news, hide the bad news.’

To the extent that Chinese families have strong stigmatizing beliefs about mental illness, if depression is viewed as a mental illness, negative family responses may be anticipated.

**Common coping and help-seeking strategies**

Most Chinese see the family as the source of emotional comfort, a belief confirmed in Ying’s [26] study of help-seeking behaviours among migrant Chinese-American women. Interviewees were asked to conceptualize and explain their condition. Those who ‘psychologized’ their problems turned to themselves or their family for help. Those who ‘somatized’ their condition sought medical help.

Kleinman’s [11] ‘explanation models’ provides a vivid demonstration of how differing individuals may be alarmed by different symptoms and interpret them in a culturally specific way. When help is sought, individuals seek a service that fits their own explanatory model. In Cheung’s [27] research, focusing on the conceptualization of psychiatric illness in Chinese patients in Hong Kong, 39% turned to self-directed coping methods (including talking to their family members or getting emotional support from friends) because they interpreted their problems as purely psychological, 22% approached Western medical facilities other than mental health specialists (they reported purely somatic symptoms), while 39% experienced mixed symptoms (and approached professional help early, involving psychiatric services much sooner than the other groups). Such findings indicate a strong relationship between help-seeking behaviours and Chinese patients’ own conceptualization of ‘illness of the mind’.

When Chinese patients present to a psychiatrist, they may have sought help from various sources (traditional herbal remedies or Chinese-speaking community workers). It is generally helpful to note the details of the patient’s previous help-seeking behaviours as this will inform the practitioner about the extent to which the patient is acculturated and the model of their depression.

**How Chinese patients may present**

As noted, many Asian regions have low reported community rates of depressive disorders, a finding reflecting a variety of determinants, especially stigma. Asian academics seeking to research depression are more likely to advertise or set up treatment clinics for those with sleep disorders, to obtain suitable subjects. Our interview of individuals and focus group discussions with Chinese people in Australia suggest that only a minority will seek referral to a psychiatrist, as a consequence of stigma and
other issues referred to earlier. They are more likely to present only after the insistence of their general practitioner or to a hospital on an involuntary basis. For those presenting to a general practitioner, common somatic features are insomnia, epigastric discomfort, dizziness, headaches and general malaise. For those presenting to a psychiatrist, insomnia, troubled thinking (both poor concentration and increased worry) and somatic concerns are commonly nominated.

However, as noted earlier, a significant percentage will affirm formal depressive features on questioning and discuss personal issues in response to direct and empathic questioning. The following are just a few examples: ‘You don’t look very happy, is there anything bothering you?’ (The linguistic negation of ‘happy’ is more comfortable to the Chinese than asking ‘Do you feel depressed?’). Or: ‘How is your mood?’; ‘Tell me some of the things you are worrying about.’ (There are Chinese words referring to ‘mood’, and combining ‘heart’ and ‘mood’, allowing the Chinese to feel comfortable about the concept of mood).

How Chinese patients expect to be helped

Lee [23] informs us that the Chinese trade name of Prozac is ‘bai-you-jie’, literally ‘undoer of hundreds of worries and sorrows’, and with a therapeutic connotation extending beyond antidepressant properties. Thus, many Chinese patients expect Western medication to provide an instant cure to all kinds of worries, without need for explanation as to how such drugs work. Some patients may request the latest brain investigatory test to eliminate any organic aetiology.

There is clear benefit in psychiatrists providing some biological description of antidepressant medication, the time it takes for antidepressants to work, their side-effects and interaction with other drugs (including herbs), and in addressing some issues about the nature of depression (e.g. the chance of recurring episodes). Many Chinese are concerned about the ‘addictive’ properties of drugs. Their knowledge about medications is more often determined by the views of friends and family rather than from medical professionals. They seldom ask their doctors enough questions about the drug they are taking, because to do so would challenge ‘authority’.

Thus, accurate information about any medication should be provided by a qualified medical practitioner, even if the patient appears uninterested. To strike a balance between providing too little or too much information is not easy, but providing pamphlets in Chinese languages is a good option [e.g. 28]. Mak and Chan [29] reported a low compliance rate among Chinese mental health patients, who often made their own decision to stop medications as symptoms subsided. Public education regarding the nature of the antidepressants is much needed. Family members are good resources to assist with compliance and keeping follow-up appointments.

It is also important to ask the patient’s preference for a family member to sit in at a session or not. As Lee [23] points out, the ‘usual’ practice of deliberately excluding kinship groups in individual psychotherapy is seen as ‘strange’ for Chinese patients.

For patients whose English skills are lacking, referral to a Chinese-speaking health professional is distinctly helpful, subject to the skills and approaches of that professional. Transcultural mental health centres have also been established in many major cities in Australia and provide better mental health services to people from culturally diverse backgrounds.

General perceptions regarding different treatment options

Despite the fact that Chinese patients will generally respond to questions about depression, there is a reason for their common initial denial or presentation via proxy symptoms – the suggestion of depression (or of any form of mental illness) has been established in our focus groups as still carrying distinct social stigma in the Chinese community. This reality, together with illness model components, ensures that most Chinese patients are hesitant to commit to an exclusively physical or psychological explanatory model of illness.

Psychotherapies (including cognitive behaviour therapy) are generally considered by Chinese patients to be expensive and ineffective. Describing the situation in Hong Kong, Lee [23] wrote that ‘the notion that a person is to abstain from work and to pay substantially for regular “mind treatment” (xin-li-zhi-liao) without any drug prescription . . . is exotic to traditional Chinese medicine and alien to Chinese people generally.’

In recent years, more and more people around the globe have turned to holistic and natural therapies. The holistic concept of ‘body and mind’ challenges the Cartesian body–mind dichotomy belief. Chinese herbal medicine and acupuncture fit into the holistic paradigm of thinking by connecting the different vital organs of the body with the ‘five elements’ of the environment, namely: wood, fire, earth, metal and water. Traditional Chinese medicine is increasingly integrated with Western approaches. Barnes [30] for instance, notes how Chinese acupuncture has been used in conjunction with psychotherapy to ‘unblock’ illnesses that are attributed to physical, emotional and spiritual ‘unease’ in the US.
Conclusion

We aim to provide background material for assisting psychiatric assessment of depressed Chinese patients who present with either somatic or psychological symptoms. A more culturally sensitive approach of trying to understand the patients’ own explanatory model is clearly important. Though Chinese patients, with their unique cultural beliefs and values, may experience depression differently from Western patients, there are some common symptoms which are reported frequently by patients from diverse backgrounds (such as insomnia, anxiety and feeling worthless). Chinese patients usually comply well with case-history taking, which may facilitate rapport building at the beginning of the interview. More direct questions regarding psychological symptoms are needed however, to unveil the true nature of the distress which will lead to an accurate diagnosis. Informing patients about the biological causes of depression is likely to assist de-stigmatization. Successfully treated patients can then be agents in educating other Chinese people about depressive disorders and understand the need for compliance with medication for themselves.

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