Depression through Chinese eyes and the implications for Australian multicultural health policy

Bibiana Chi-wing Chan,[1] Gordon Parker, [2] Maurice Eisenbruch[3]

Presented at the First International Congress of Qualitative Inquiry, University of Illinois,, 5-7th May 2005.

Abstract

Chinese living in Sydney represent Australia's largest-growing non-English speaking group. This study seeks to explore the dance between culture and depression. A combined qualitative and quantitative methodology by survey and focus groups enabled comparison of Australian and Chinese groups while exploring meaning. Self-nominated symptoms of depression by survey informants showed close resemblance between Chinese and Australians except for some idiomatic expressions that reflected cultural salience. Inspection of qualitative data indicated substantial differences between the Chinese and Australian at the conceptual level of **what** 'depressive experience' is; **how** to make sense of it, **when** medical or professional help is warranted and **how** to seek help. The two methods compliment each other in unfolding the complex relationship between culture and depression. The emotional experiences of the Chinese living in Western society like Sydney provide good empirical basis for this purpose.

From the quantitative data, we learnt that overseas-born Chinese and Australians experienced similar symptoms but used different help-seeking strategies. Qualitative data illuminated what were the reasons and decision making process involved. Chinese who were born in Australia or migrated at a young age showed differentcultural practices compared to those who grew up in non-Western environment. The stereotype is that Chinese somatize, Westerners psychologize – but the findings show that somatization is not unique to Chinese.

Health policies in culturally diverse settings such as Australia depend upon a clear understanding of such 'idiomatic' maps of depression and 'depressive experiences'. Health systems can plan and deliver culturally competent interventions

[1] Mood Disorder Unit, Black Dog Institute, School of Public Health and Community Medicine, and Centre for Culture and Health, University of New South Wales
[2] Mood Disorder Unit, Black Dog Institute
[3] Centre for Culture and Health, University of New South Wales
Correspondence address: Bibiana Chan, Black Dog Institute, Hospital Road, Randwick, 2031, NSW, Australia.
Email: bibi.chan@unsw.edu.au

I. Background

The aim of this research is to discover how Chinese in Sydney make sense of their 'emotional distress' or in research language: their 'depressive experiences'. The informants were drawn from the Chinese living in Sydney. Chinese immigrants represent Australia's largest-growing non-English speaking group. Combining all dialects, Mandarin, Cantonese, Hokkien, Teo Chieu, Hakka, Chinese is the most spoken language after English in Australia (ABS 2001). Smith and Bond (1999) criticize early researches in cross-cultural psychology that frequently simplified or polarized culture into Western and Chinese. However, in reality, such distinction is not that clear-cut as the 'Information Superhighway' has taken off in the last 2 decades. For the purpose of providing 'a point of reference', one may take the cultural division at a 'symbolic' level. In recent years, the exchange of knowledge and information has also been sped up by the process of migration and acculturation (Bhugra and Mastrogianni 2004), it is no longer just something read or seen on a small TV screen, but something encountered on a daily basis. The complexity of such exchange or in anthropological term, acculturation (Berry and Sam 1997), is far beyond what a tick-boxes kind of questionnaire can address. It is not only appropriate but also pressingly needed to conduct qualitative studies to unveil the effect of migration and acculturation on these Chinese-Australians in Sydney. The direction of cultural exchanges go in both ways, as the Chinese become more and more 'Westernized', Australians also pick up some Chinese life ways. One example to illustrate this point is: in a survey of households in Queensland, Australia (Bye, 2000); more than 30% of families surveyed had a Chinese '*wok*'(traditional round-shaped cooking utensil) and a similar proportion of people had used alternative therapy (including Chinese acupuncture) in the past year. In most Western societies, one in five people suffered from clinical depression to various degrees at some stage in their life (Beyondblue 2005). This

study is particularly important to uncover how similar or different are the 'depressive experiences' encountered by the Chinese and the Australians.

II. Methods:

The meaning and conceptualization of 'clinical depression' within the Chinese culture is not well defined. In the quantitative survey[4], informants were probed by answering 'yes' or 'no' to a continuous period of 'low mood, feeling of hopelessness and helplessness, loss of self-esteem and self-confidence' for more than 2 weeks. In the qualitative focus groups, two vignettes were presented to the participants: 1 female (with insomnia, anhedonic and feeling irritable) and 1 male (more severe case with dull gaze, weight loss and psych-somatic retardation) experiencing symptoms of clinical depression. Brief life circumstances of the vignettes were also given. It has been shown in the pilot study that the vignettes served as a projection test - discussion generated within such setting revealed the participants' own beliefs about mental illness. This research utilized a mixed methodology with quantitative survey (n = 528) providing the power for making generations of the 'phenomenon' and the 16 community focus groups (run in three different languages) providing the important insight into the contexts in which such phenomenon was observed. Survey informants and focus group participants were all given the most commonly used acculturation measure in North America: Suinn-Lew Self-Identification Acculturation Scale (SLAS, Suinn et.al.1992) adapted to Australia's local context as a formal measure of their level of acculturation. Informants were also asked to nominate their attributions of what might have caused their distress and their subsequent help-seeking strategies. Focus group participants were given a 'Mental Distress Explanatory Model Schedule' (Eisenbruch, 1990) to tap into what they believed were possible causes of mental distress. Will the Chinese seek-help through the 'Western medically prescribed' model or go through other channels? This is one of the questions

[4] The full description of the quantitative survey was reported in a paper by the same authors currently under review.

the researchers most want to find the answers. By taking a macroscopic approach in the focus group discussion, the researchers were able to gain some insight into what were the most troubling symptoms, what explanatory models the Chinese attributed to the distress and how decisions were made regarding help-seeking strategies.

II. Survey Results:

A. Depressive episode

The mean age of the three Chinese groups reflected the characteristics and the nature of their migration. Highly acculturated Chinese recruited were younger than the other groups and also migrated at a younger age or were born in Australia. They were the top 25% in terms of SLAS score. 86% of this group preferred an English questionnaire to a Chinese one. Most of them were children of Chinese immigrants. This subgroup was also more educated. This can be explained by the Chinese traditional emphasize on children's education (Stevenson, 1994). For the low acculturation subgroup, over 95 % answered a Chinese questionnaire and nearly 40% were not in the workforce. They most likely migrated within the 'family reunion' category to join their adult children working in Australia who might have sponsored their immigration application. The current age as well as the age at migration was older and they reported a lower percentage of 'depressive episodes' than the highly acculturated group but showed very similar pattern with the middle group. The middle group can be considered as the 'bi-cultural' group who migrated to Australia in their adulthood (mean age at migration = 23.9 yr). Almost three quarters were actively involved in the work force and majority of them were integrated into the mainstream Australian society (only 14% reported to be associating exclusively with other Chinese). However, 69% of this group still preferred a Chinese questionnaire. Informants responded to the prompt on depression: for episodes lasting longer than 4 weeks that impaired daily life, Chinese

across the 3 groups reported significantly lower percentages than the Australians (as shown in Table 1). If any episode longer than 2 weeks was included, only the two lower acculturation groups showed significant difference to the Australians. Across all groups there were slightly more women.

Table 1: Demographics and percentage distribution of informants' depressive experiences

	Chinese			Australian
Showing degree of acculturation	low n = 109-120	Bi-cultural n =119-130	High n =77	n = 137-143
Age (yr)	43.9 SD = 15.4	35.4 SD = 13.0	29.1 SD = 12.1	41.5 SD = 17.9
Bachelor Degree	22%	30%	47%	22%
Not in workforce	38%	24%	9%	9%
Age at Migration (yr)	33.7 SD = 14.1	23.9 SD = 10.7	9.3 SD = 10.6	N/A
SLAS score (from 1-5)	**1.86** SD = 0.18	**2.28** SD = 0.14	**2.98** SD = 0.37	N/A
Depressive Episode > 2 wk	28.8%	28.5%	37.7%	49.2%
Depressive Episode >4 wk	16.1%	10.8%	19.5%	28.8%

B. Troubling Symptoms

There were some qualitative prompts within the survey which allowed the informants to report the four most troubling symptoms of their episode. Due to the small percentage of Chinese admitting to have experienced a 'depressive episode', a different categorization was used to obtain a more comparable number of informants within each group. Table 2 shows the percentage distribution of most troubling symptoms, comparisons were made between respondents answering either Chinese or English questionnaire. Preferred questionnaire language can be taken as a proxy 'linguistic acculturation' measure (Clement, 2001). The top six most troubling symptoms were very similar across the groups. It is worth mentioning that we have extended

criterion for inclusion into the symptom feeling 'depressed' to: any idiomatic references such as '*xin-qing-bu-hau*' (literally means mood is not good), 'fell into a dark hole' and 'feeling grey' etc.

Table 2: Weighted score of most troubling symptoms

	Chinese		**Australians**
Questionnaire language	Chinese-Qn respondent n=71 Weighted score*	Eng-Qn respondent n=47 Weighted score	Eng-Qn respondent n=65 Weighted score
Insomnia	**67** *(1)#*	**20** *(2)*	**18***(6)*
depressed	**42** *(2)*	**39***(1)*	**24** *(5)*
Anxious & tense	**31** *(3)*	**25***(5)*	**46** *(1)*
X motivation	**20** *(4)*	**27***(4)*	**29***(2)*
withdrawn	**18** *(5a)*	**14***(6)*	**25** *(3a)*
Hopeless	**18** *(5b)*	11*(10)*	10 *(11)*
Sadness	9 *(12)*	**29** *(3)*	16 *(7)*
Fatigue	7 *(14)*	**20***(6)*	**25** *(3b)*

* The 1st nominated symptom was given 4 points; 2nd nominated symptom 3 points; 3rd 2 points and 4th 1 point.
#The number in bracket is the rank for that symptom.

C. Salient explanations

Informants were asked to nominate what they thought as the likely causes of their depressive experiences. As shown in Table 3, there are common themes, such as relationship breakdown, life stress, and work-related stress. The difference between the Chinese (no matter how acculturated) and the Australians was that Chinese frequently nominated 'family challenges' as contributing factors where as Australians related their depression to other illness or health issues. Not surprisingly, the lower acculturation Chinese experienced more migration-related stress, such as language and adjusting to a new environment.

*Table 3: Explanation Models of informant of previous depressive experiences**

	Chinese		Australian	Analysis
Questionnaire(Qn) language	Chinese Qn respondent n=59 %	Eng Qn respondent n=44 %	English Qn respondent n=60 %	χ^2 df = 2
Life Stress	11.9	15.9	23.3	2.82
Work Stress	16.9	15.9	8.3	2.19
Relationship	15.3	22.7	20.0	0.97
Study-related	11.9	13.6	3.3	4.01
Health-related	10.2	4.5	20.0	6.01*
Family Challenges	20.3	22.7	6.7	6.21*
Finance	6.8	9.1	1.7	2.96
Migration	11.9	4.5	N/A	1.69 df=1

*more than one EM was allowed.

D. How to look for help

(i) For mild transient episodes (2-4 weeks)

More Australian would have visited their primary physicians, where as Chinese in the low acculturation group were likely to seek help from family and friends.

Table 4: Help Sought at various severity of depressive episodes

Help Sought	**No help**	**GP**	**Psychologist**	**Psychiatrist**	**Herbal remedy**	**Friends or family**
	Episode between 2 to 4 wk					
Low acc. Chin (n=12)	7 (58 %)	2 (17%)	0	0	0	**3 (25%)**
Bi-cultural Chin (n=21)	**15 (71%)**	3 (14%)	0	1 (5%)	1 (5%)	2 (10%)
High acc. Chin (n=12-13)	**9 (75%)**	3 (25%)	0	0	1 (7%)	0
Australians (n=24)	12 (50%)	9 (38%)	4 (17%)	3 (13%)	4(17%)	3(13%)
	Episode > 4 wk					
Low acc. Chinese (n=18-19)	3 (17%)	8 (44%)	4 (22%)	4 (22%)	**9 (47%)**	2 (11%)
Bi-cultural Chinese (n=14)	4 (29%)	5(36%)	5 (36%)	2 (14%)	3(21%)	3 (21%)
High acc. Chin (n= 14)	2 (14%)	7 (50%)	**8 (57%)**	4 (29%)	**6 (43%)**	2 (13%)
Australians (n = 36)	2 (6%)	**26 (72%)**	14 (39%)	**15(42%)**	12(33%)	6 (17%)
*Statistic analysis was not conducted due to small number of informants in each group.						

(ii) For more severe episode (over 4 weeks)

For a more intense episode, over 70% of Australians would have consulted their primary physicians where as only 50% of the Chinese did so.

The high acculturation group seemed to prefer the service of a psychologist to a psychiatrist. Focus groups revealed that the 'mere act of seeking help from psychiatrist' was still highly stigmatized by Chinese peers. A high percentage of low acculturated Chinese would have used herbal remedies (self-prescribed or from a herbalist). It is worth mentioning that more than 30% of Australians also have resorted to herbal remedies, which included any form of alternative medicine. Australians are as likely as the Chinese to seek help from friends and relatives.

III. Focus Group Findings:

Table 4: Real scenarios of emotional distress volunteered by participants.

Acc level*	Inf.	Context	Symptoms	E.M.	Help
L	F 70+	Sydney 04 F friend 60+	Insomnia, breathiness, emotional pain	Family relationship. Finance	Confide to friend
L	F 60+	Sydney 04, Husband	Lack interest, suicidal, withdrawn	Family (In-laws), save face	Community Centre for information
L	F 60+	Sydney89-04 M relative 40+	Dull gaze, depressed, suicide attempts X think straight	Lang. Work Stress	Medical, Social Benefit.
L	F 60+	China 80s F 50+ Neighbour	Irritated, mood not good, lose weight	Balance upset SJSR	Chinese Herbalist
B	F 26	Sydney 04 Self	'depressed' emotional problems	Life Stress	Confide to friend
B	F 29	China 90s Grandma	Body ache & pain, unwell, insomnia	Medical, mentally ill	Hospitalization
B	F 51	Sydney 02-04 F friend.	Tearful, Sad, insomnia	Grief	Primary physician, Friend

B	F 50+	Sydney 2004 M friend	Irritated, low mood, loss of essence	Family challenges, Work, Finance	Suicide (jumped off rail)
H	F 18	Sydney 04 M friend	'Depressed'	Brain chemistry	Internet Information
H	F 24	Sydney 04 Sister	Low-self esteem, tense	Academic pressure, Family Expectation	Smoking (self-medication)
H	M 30+	Sydney 04 Self	Hopeless, loss confidence, low self-esteem,	Life Stress Suppressed emotions	Medical, Support Group
H	F 33	Sydney 00s Mother	Mood very low	Medical	Mother reluctant to seek medical help even own daughter is a doctor.

* L - low acculturation; B - bicultural; H – high acculturation according to participants' SLAS scores.

Symptoms, Explanation models and Help Sought

The 12 real scenarios presented here are true stories voiced by the focus group participants. All reported their stories as very similar to what has been described in the 2 vignettes. There is one report of SJSR (Chinese idiomatic expression for neurasthenia); a popular 'proxy' term for depression in the 1980s (Lee S, 1995).The more acculturated Chinese seem to adopt a more medical approach though there is still much resistance to taking medication and consulting psychiatrist. Many of our informants, both Chinese and Australian alike, talked about the importance of getting emotional support from family and friends. Perhaps the Australians have higher medical literacy and access to existing professional services, they seem to readily adopt a more 'medical' model as prescribed by Western medical professionals. From the narratives collected from focus groups, it is apparent that the Chinese are seeing primary physicians for reasons different from their Australian counterparts (e.g. insomnia but not 'low mood').

III. Discussion

Deep in Chinese antiquity, there has been a clear link between 'body and mind'. The term _ + _ (*ju_n*) or_ _ (*y_uyù*) is the closest equivalent to denote the Western term 'depression' which means _ _ _ _ (*xintông-t_fán*) (TCP, 1974). A literal translation would be **'heart+ache+body+irritated'.** When asked whether they have used 'Chinese herbal remedy' to relieve their emotional distress, about 40% of Chinese informants in the low acculturation group in the survey said yes. In one pilot focus group, a participant from a low acculturation group, himself a practising Chinese herbalist, described herbal remedy that improves the 'circulation' of the liver system as one solution to the vignette's presenting symptoms. Thus it is extremely important to hear the narratives of the Chinese in order to understand how they make sense of their depressive experiences. The narratives gathered from these focus groups are crucial for future planning of services to better cater for community from Chinese cultural background and other diverse cultural communities.

Inspecting the most troubling symptoms nominated symptoms in more details, insomnia came first for both Chinese subgroups. Parker et. al. conduct a similar study to compare Chinese-Malaysians and Australian depressed patients and found that Chinese also ranked insomnia very high (Parker et al. 2001). In this study, the symptom 'fatigue' was ranked third and sixth by the Australians and the highly acculturated Chinese respectively, but was only ranked 14th by the other Chinese subgroup. In recent years, there has been much interest in chronic fatigue syndrome (Ward 1998). The response patterns shown in Table 2 can shed some light on the cultural saliency of some bodily sensation and emotional states. It is interesting to see how the highly acculturated Chinese show close resemblance to the other two groups demonstrating a moderating effect of culture.

The proposition that the less acculturated Chinese experiencing emotional distress may hold a different ticket when consulting primary physicians is supported by a study of patients attending primary health care clinics (Üstün and Sartorius, 1995) at 15 centres in 14 countries, results showed that on an average 5.3% of the all patients gave the main reason for visit as 'having psychological problems'. Centre at Santiago, Chile has the highest percentage (13.2%), followed by Groningen, Holland (12.8%) and Paris, France (11%). The Asian countries have the lowest percentage: Shanghai, China; Nagasaki, Japan and Bangalore, India (0.2%, 1.3% and 1.3% respectively).

IV. Implications

The message is: integrate. There should be substantial overlap between different sectors indicating the importance of collaborative work and inter-disciplinary knowledge (see Figure 1) with a view to endorsing and harnessing the Chinese view of what they call depression. The authors of the paper straddle two stools. The Black Dog Institute (Parker and Andric 2005) has made a continuous effort to update primary physicians and psychologists on the latest diagnosis models and effective interventions. The socio-cultural support section has been strengthened tremendously by establishing a first of its kind 'Consumer Resource Centre' to provide a state-of the-art facility for mental health consumers and caregivers. The Centre provides a meeting place for the public and consumers alike to seek information and attend educational programs. The Centre for Culture and Health (CCH) seeks to promote cultural competence in health education and research. CCH has developed a framework for cultural competence research (CCH, 2005) that is applicable to mental health work. The present paper is a first step towards the straddling of the two stools.

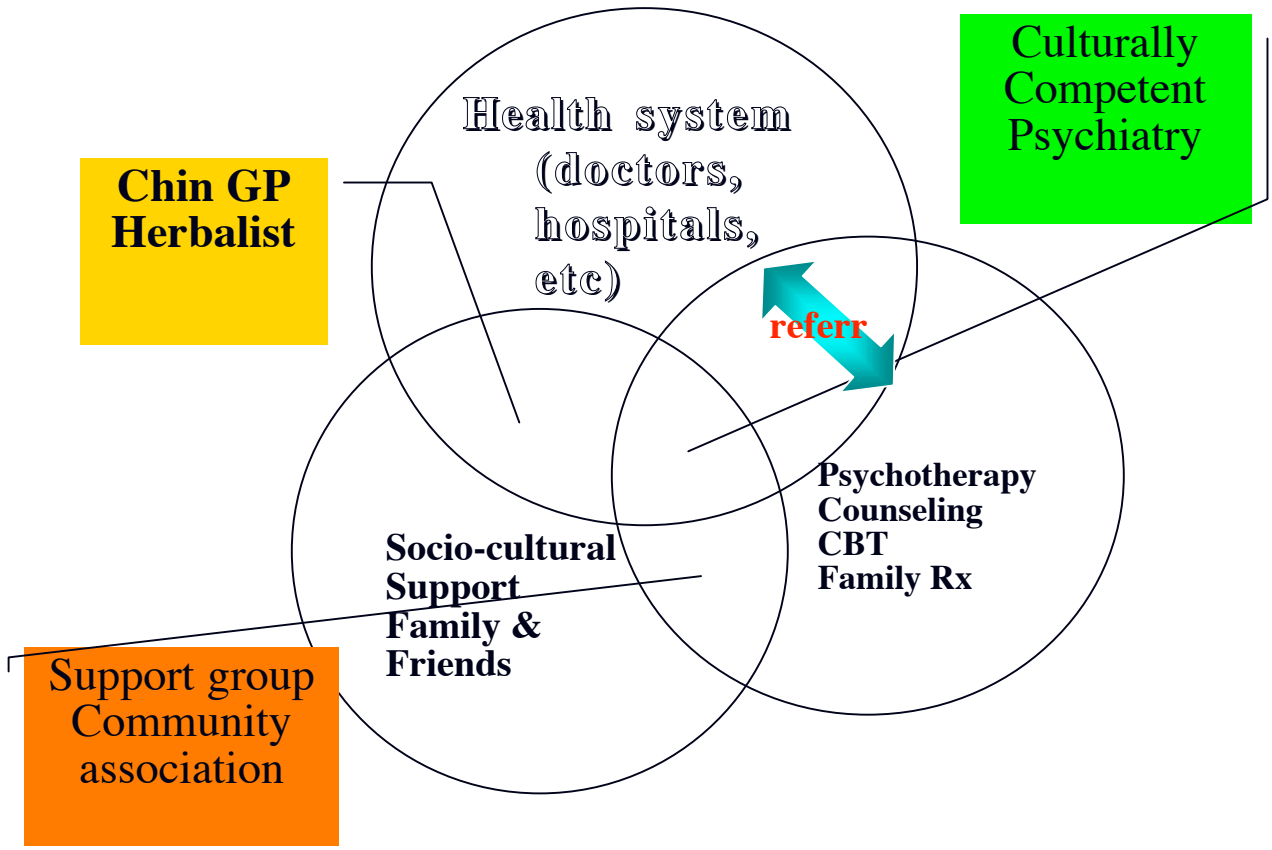

Figure 1: Implications for 'Culturally Competent Psychiatry'

Acknowledgments
We thank the NHMRC (Program Grant 2223708) and Centre for Mental Health for funding support, Dusan Hadzi-Pavlovic for statistical assistance, and all participating medical centres and community organizations. We are also grateful to all participating doctors and focus group attendants enabling the study to be undertaken.

References

Australian Bureau of Statistics (2002) 2001 Census Basic Community Profile and Snapshot www.abs.gov.au date accessed 020505

Berry, J. W. and Sam, D. (1997) Acculturation and Adaptation. In J. Berry, M. Segall and G, Kagitcibasi (Eds.) Handbook of Cross-Cultural Psychology Vol. 3 Social Behavior and Application. Boston: Allyn and Bacon

Bhugra D and Mastrogianni A (2004) Globalisation and Mental Disorders: Overview with relation to depression. *British journal of psychiatry* **184,** 10-20

Beyondblue (2005). http://www.beyondblue.org.au/index.aspx?oid=443 accessed: 030505

Bye, C. (2000). Finding Our Inner Hippie. Sydney Morning Herald. Sydney.

Centre for Culture and Health (2005). http://cch.med.unsw.edu.au/cch.nsf/website/Research.projects.HealthPolicy date accessed: 02052005.

Clement, R. K., Noels, A., et al. (2001). "Interethnic Contact, Identity, and Psychological Adjustment: The Mediating and Moderating Roles of Communication." *J Social Issues* **57**: 559-577.

Eisenbruch, M. D. (1990). "Classification of natural and supernatural causes of mental distress: Development of a Mental Distress Explanatory Model Questionnaire." *Journal of Nervous and Mental Disease* **178**: 712-719.

Lee S and Wong, K. (1995). "Rethinking neurasthenia: the illness concepts of shenjing-shuairuo among Chinese undergraduates in Hong Kong." *Culture Medicine and Psychiatry* **19**: 91-111.

Parker, G, and Andric, L., Eds (2005) Black Dog Institute Annual Report 2004, Sydney.

Parker, G., Cheah, Y.-C., et al. (2001). "Do the Chinese somatize depression? A cross-cultural study." *Soc Psychiatry Psychiatr Epidemiol* **36**: 287-293.

Smith, P. B. and Bond, M. H. (1999). Social psychology across cultures. Boston: Allyn and Bacon.

Stevenson, H., Chen, C. S., et al. (1994). Chinese Families. In J. Roopnarine and B. Carter (Eds) Parent-Child Socialization in Diverse Cultures. New Jersey: Ablex.

Suinn, R. M., Ahuna, C. et al. (1992). The Suinn-Lew Asian self-identity acculturation scale: concurrent and factorial validation. *Educational and Psychological Measurement* **52**: 1041-46.

TCP (1974). Encyclopedia of Chinese Phrases [in Chinese]. Taipei, Taiwan China Press _____.

Üstün, T. B. and Sartorius, N. (1995). Mental Illness in General Health Care: An international study. Chichester: John Wiley & Sons.

Ward, N. (1998). "Sociosomatics and Illness Course in Chronic Fatigue Syndrome." *Psychosomatic Medicine* **60**: 394-401.