Depression in the Planet's Largest Ethnic Group: The Chinese

Gordon Parker, D.Sc., M.D., Ph.D., F.R.A.N.Z.C.P.

Gemma Gladstone, B.A. (Hons)

Kuan Tsee Chee, D.P.M., F.A.M.S., M.R.C.Psych.

Objective: The authors reviewed the evidence for the claim that the Chinese tend to deny depression or express it somatically, examined the possible determinants of those characteristics, and explored implications of the findings for the diagnosis and management of depression in China and for psychiatry in the West.

Method: This paper reviews and interprets original studies and literature reviews considering emotional distress, depression, neurasthenia, and somatization in Chinese subjects.

Results: Interpretation of the literature is complicated by the considerable heterogeneity among people described as "the Chinese" and by numerous factors affecting collection of data, including issues of illness definition, sampling, and case finding; differences in help-seeking behavior; idiomatic expression of emotional distress; and the stigma of mental illness. Despite difficulties in interpreting the literature, the available data suggest that the Chinese do tend to deny depression or express it somatically.

Conclusions: The existing evidence supports the hypothesis that the Chinese tend to deny depression or express it somatically. However, Western influences on Chinese society and on the detection and identification of depression are likely to have modified the expression of depressive illness quite sharply since the early 1980s. Analyzing these changes may provide useful insight into the evolution of the diagnosis of depression in Western and other cultures.

(Am J Psychiatry 2001; 158:857–864)

The suggestion that the Chinese have lower rates of depression is most frequently interpreted as reflecting denial of the illness or a tendency to express depression somatically. These interpretations are, at best, crude simplifications of complex processes. Cultural influences challenge the definition and diagnosis of psychiatric disorders to an extent that is often insufficiently appreciated. The experience of illness and discomfort, whether physical or emotional, is shaped by multiple sociocultural factors that, in turn, influence the nature of illness expression, coping styles, and help-seeking behaviors.

In 1998 there were almost 1.3 billion Chinese in the world. The vast majority lived in mainland China, but 37 million lived elsewhere, including Taiwan. The Chinese are the world's largest ethnic group, representing 22% of the planet's population. There are many problems in addressing the topic of depression in ethnic Chinese, including any assumption that this population is homogeneous. First, there are 55 officially recognized ethnic groupings in mainland China, and hundreds more are identified unofficially (1). There is further heterogeneity among the many groups outside mainland China who have been exposed to various sociocultural factors, including a range of political and social ideologies and different levels of industrialization, urbanization, and Westernization. Second, like other cultures, the Chinese world does not stand still. There has been an evolution within Chinese society in views about the causation of mental illness, from imputing superstitious and supernatural processes to physical and—finally—psychological processes, but this has occurred at different rates across the multiple Chinese communities. Third, the substantial political, economic, and societal changes in mainland China reflected in the successive leaderships of Mao Zedong, Deng Xiaoping, and Jiang Zemin would be expected to influence the true prevalence of depression as well as its detection and reporting. Finally, access to and interpretation of much of the data remain problematic.

This paper reviews evidence for the claim that lower rates of depression among the Chinese reflect denial of the illness or a tendency to express depression somatically. In addition to interviewing Chinese psychiatrists for guidance about relevant studies, we selected studies for review if they specifically considered emotional distress, depression, neurasthenia, or somatization in Chinese subjects. We included original research articles and review articles. One Chinese-language community survey report was reviewed after it had been formally translated by two independent translators. Literature searches were conducted by using both medical and social science databases.

Epidemiology of Depression in Chinese Societies

The apparent rarity of depression in China was noted by Western observers in the early 1980s (2), but few community-based studies have examined this issue, and their findings are difficult to interpret. A psychiatric survey of mental disorders was undertaken in 12 regions of China in 1982 and repeated with almost identical case ascertainment strategies in seven regions in 1993 (3). Teams consisting mainly of psychiatrists and psychologists surveyed people aged 15 years and older in urban and rural households. They used a variety of psychological questionnaires and conducted clinical interviews using a Chinese manual of mental disorders and ICD categories. Of 19,223 people surveyed in 1993, only 16 fulfilled the criteria for lifetime affective disorder. The lifetime prevalence of affective disorder was 0.08%, and the point prevalence was 0.05%, but both prevalence rates were higher than those found in the 1982 survey. At face value, the 1993 data suggest the community rate of depression was several hundreds of times lower than in the United States.

A study of the global burden of disease (4), which analyzed a different set of data from 1990, found that unipolar major depression was the second largest contributor to the burden of disease in mainland China, accounting for 6.2% of the total burden. The study estimated prevalence rates of 0.4% for bipolar disorder and 1.4% for unipolar major depression. The analysis also suggested a 2.3% one-year incidence of unipolar depression, compared to annual incidence rates of 2.5% for manic episodes and 10.3% for major depression found in the United States National Comorbidity Survey (5). However, the methods used in the analysis of the global burden of disease involved "informed estimates" by experts when no data were available for a region (4). For China, these estimates are likely to be indicative at best.

Several national community studies undertaken in Taiwan have generally identified a low rate of depression compared to that in other countries. For example, one cross-national overview of epidemiological survey data reported a lifetime prevalence of 0.3% for bipolar disorder in Taiwan, compared to 0.4% to 1.5% in 10 other countries (6). Similarly, the lifetime prevalence of major depression was 1.5%, compared to 2.9% to 19.0% elsewhere. The authors of the overview interpreted the prevalence rates for Taiwan as unrealistically low, particularly because Taiwan was an industrialized nation and DSM-III had been widely used there. The authors suggested that "social stigma and cultural reluctance to endorse mental symptoms" might be responsible.

The original report of the Taiwan survey (7) was based on data gathered from 1982 to 1986 by using the National Institute of Mental Health Diagnostic Interview Schedule, which was also used in the Epidemiologic Catchment Area (ECA) study in the United States (8). The instrument was translated into Chinese for use in Taiwan and was administered by trained lay interviewers. The results were used to generate DSM-III diagnoses. This consistent method had the potential to clarify epidemiological estimates and determinants of regional differences. The study included large representative samples of adults in metropolitan regions, two small towns, and six rural villages. Lifetime prevalence rates in these three settings were 0.16%, 0.07%, and 0.1%, respectively, for mania, compared with 0.9% in the ECA study; 0.88%, 1.68%, and 0.97% for major depression, compared with 5.2% in the ECA study; and 0.92%, 1.51%, and 0.94% for dysthymia, compared with 3.0% in the ECA study.

The results from Taiwan can be interpreted in a number of ways. They may indicate a genuine rarity of true depression; issues in definition, sampling, and case finding; a low level of reporting of depressive symptoms; or the existence of "depressive-equivalent" conditions.

Clinical Detection of Depression

Several studies in the 1980s established that diagnoses of depression in clinical settings were made less commonly in mainland China than in Western countries. For example, a World Health Organization study of prevalence rates for depression diagnosed according to ICD-10 criteria in general health care settings in 15 countries found that China (Shanghai) had a lower than average rate of 4.0% (9). Xu (10) reported that affective disorder diagnoses at the Shanghai Mental Health Centre accounted for a mere 1.2% of total admissions between the late 1950s and the mid-1980s. Kleinman (11) reported that only 1% of people attending a psychiatric outpatient clinic in Hunan during a 1-week period were diagnosed as depressed, but 30% were diagnosed as neurasthenic. Lin (12) reviewed statistics from mainland China and reported that less than 3% of outpatients and about 1% of inpatients were diagnosed as depressed.

Differences in help-seeking behavior may influence the reported prevalence rates. For example, the Chinese in Taiwan tend to use indigenous practitioners for treatment of "illness" and Western-trained physicians for "disease" (13). Since emotional disturbance is not typically considered within the realm of disease by many Chinese patients, depressed individuals might not readily present to psychiatric services. Thus, differences in prevalence rates may reflect variations in help-seeking patterns rather than intrinsic symptom patterns.

Alternative Patterning or Presentation of Depression

If "true" depression presents with a "non-Western" pattern, interpretation of this alternative presentation may influence epidemiological estimates.

The term "neurasthenia" was popularized by the neurologist Beard (14). Derived from Greek, it means a "lack of nerve strength" and came to denote "exhaustion of the nervous system" (14), a state characterized by fatigue and weakness accompanied by a range of physical and psychological symptoms such as nonspecific aches and pains, dizziness, gastrointestinal upsets, and irritability.

The concept of neurasthenia was introduced in China in the early 1900s and was commonly understood by the Chinese to mean "neurological weakness," described as *shenjing shuairuo*. These words translate as a weakness of the channels carrying vital energy, or *qi,* through the body (15). *Shenjing shuairuo* became widely used diagnostically by psychiatrists and other medical practitioners, who viewed it as a state determined by the interaction between an inherited neurotic tendency and environmental stress (2, 16), and it was accepted as a common illness by the general public. By the 1980s, as many as 80% of psychiatric outpatients in mainland China were diagnosed as primarily "neurasthenic" (2, 17), and up to one-half of general and psychiatric Chinese outpatients sought treatment for self-diagnosed neurasthenia (18–20).

Yan (16) noted that patients presenting with a clinical picture of insomnia, dizziness, headache, poor concentration, and related complaints would commonly receive a diagnosis of neurasthenia. Cheng (21) explained that "it is quite obvious that psychiatric patients in less developed societies without knowledge of mental disorders often interpret their illness as physical in origin and report only somatic discomforts to their doctors. This is a question of illness behaviour." Rather than a somatization disorder, *shenjing shuairuo* is more a generic label applied to wide-ranging symptoms, including somatic symptoms (such as insomnia, fatigue, and dizziness), cognitive symptoms (such as poor memory or unpleasant thoughts), and emotional symptoms (such as vexatiousness, excitability, or nervousness), in addition to any depressive symptoms.

The concept of neurasthenia as a nervous system disorder fits well with the traditional Chinese epistemology of disease causation on the basis of disharmony of vital organs and imbalance of *qi* (22, 23). The concepts of balance and conservation, in particular a balance of positive and negative forces (*yin* and *yang*) and proper proportions of the five elements (wood, fire, earth, metal, and water) influence Chinese interpretations of physical and mental health and illness. Disorder is viewed as a result of an imbalance of *yin* and *yang* that may be caused by external pathogens such as cold or damp and that disturbs the normal functions of vital fluids and visceral systems, including *qi* circulation.

Neurasthenia is a nonstigmatizing diagnosis that is conceptually distant from psychiatric labels and their imputation of insanity, which has been perceived as degrading by patients and families. Lee (24) described the popularity of *shenjing shuairuo* as the "indigenization of a culture-friendly condition," while Kleinman (11) noted that Chinese patients, as well as their psychiatrists, actively preferred such a label to the psychiatric label of "depression." Lee also highlighted the lack of appeal of the word "depression" to Chinese people. Depression may be translated as *yi* ("repress" or "restrain"), *yu* ("gloomy" or "depressed"), or *zheng* ("disorder"), all of which have implications that are less acceptable than the lay interpretation of *shenjing shuairuo*.

Zhang (25) suggested that the long-standing attachment to *shenjing shuairuo* in mainland China might also be the result of strong political influences, such as the concept that only counter-revolutionaries are unhappy. During the Cultural Revolution (1966–1976), depression and other forms of mental distress were viewed by Maoists as an expression of wrong political thinking (25). Studying psychology was largely outlawed from 1949 to 1980 because of its alleged incompatibility with correct political thinking. Mao Zedong declared that psychology was "90 per cent useless" and that the remaining 10 per cent was "distorted and bourgeois phoney science" (26). Such views worsened the social stigma of mental illness in a culture where the expression of emotional suffering was already discouraged, and any individual expressing emotional unease or sadness risked being seen as politically antagonistic. As noted by Lee (15), "*shenjing shuairuo* functioned as a social mantle for psychosocial distress, enabling people to avoid political denunciation as well as social stigma."

Thus, components of Chinese culture, traditional medicine, and the political landscape helped drive a preference for the illness description of *shenjing shuairuo* as a nonstigmatizing composite diagnostic category *and* an etiological statement.

In 1978, Deng Xiaoping abandoned Maoist socialism, opening China's economy to the world and its culture to Western influences, including the DSM-III criteria published in 1983. Lee (15) noted that, since the post-Mao era, a "confluence of historical, social as well as rational and global economic forces have magnified and…transferred neurasthenia…into the popular 'Western' disease category of depression." In 1982 Kleinman (2) observed that 87% of neurasthenic patients in Hunan could be reclassified as having DSM-III "major depression." Kleinman's report was seminal, according to Lee (15), as Chinese psychiatrists and physicians recognized that depression responded to antidepressant drugs, while "no drug has ever been labelled as anti-neurasthenic." Subsequent reports also argued that *shenjing shuairuo* was overused as a diagnostic term and found that many patients diagnosed as having *shenjing shuairuo* could be reclassified as having a DSM-III diagnosis of depression or some other mental illness (27–29).

Lee (15) observed that in the mid-1980s, Chinese academic psychiatrists began, with "alacrity," to abandon the diagnosis of neurasthenia in favor of the diagnosis of "depression." Nevertheless, even in the 1990s, neurasthenia remained a more common diagnosis in Chinese patients

than in other populations, even in Western community studies that defined neurasthenia by using ICD-10 criteria (30). This suggests that patients would continue to be given the diagnosis of neurasthenia as long as the diagnostic category is available for use. Of course, proponents of Chinese nosological models could equally argue that many cases of DSM-III major depression could be reclassified as cases of neurasthenia or *shenjing shuairuo*.

All diagnostic systems possess elements of arbitrariness that reflect the paradigm that is currently in vogue. Interpretation of findings on depression in mainland China should consider whether the study occurred before or after the early 1980s, when there was a substantial shift in the approach to classification. We might expect that epidemiological data on depression in the Chinese—as in other populations—will vary as diagnostic systems continue to evolve.

Diagnostic Practice

A number of publications have outlined differences in diagnostic practices that may influence the reported rates of depression among the Chinese. For example, Chinese psychiatrists have tended to take a broad diagnostic view of schizophrenia (11), with the result that some patients with affective disorders have been given a diagnosis of schizophrenia. Failure to include the less severe and more common depressive disorders would have a great impact on reported rates of depression. For example, Lee (15) noted that "depressive neurosis" was rarely diagnosed by Chinese practitioners before the late 1970s.

In a study comparing DSM-III diagnoses with diagnoses made by Chinese psychiatrists using the Chinese diagnostic criteria in 116 patients in Shanghai, one-half of those who received a DSM-III diagnosis of an affective disorder received a different diagnosis, including schizophrenia, from the Chinese psychiatrists (31). Anxiety and neurasthenia were commonly diagnosed when depression was accompanied by multiple somatic complaints. Another study compared the response of clinicians from Shanghai, Nagasaki, and Seoul to videotaped interviews illustrating patients with an affective disorder (32). Affective psychosis was diagnosed by 65% of clinicians in Nagasaki but by only 23% of the Shanghai clinicians.

Bond (26) stated that separate diagnoses of either anxiety or depression rather than neurasthenia were more likely to be made for Chinese patients when clinicians were able to explore symptoms more thoroughly. In all Asian countries, the number of psychiatrists is low, and many assessments are limited to minutes. Distinguishing the subtleties of potentially overlapping and comorbid disorders may be very difficult in these circumstances, thus encouraging the use of a less specific diagnosis.

Sharing of lexicons and classification systems could reduce the diagnostic variation between Chinese and Western populations. However, Lee (33) noted that the frequent adjustments in the Western nomenclature of affective disorders have perplexed Chinese psychiatrists and that translation has been difficult. For example, "major depression" is translated as *zhong xing yi yu zheng* ("severe depression") so that "severe major depression" becomes "severe severe depression."

A national nosological system has been developed in China. A product of the post-Mao era of "scientism," this system has appealed to Chinese psychiatrists and improved psychiatry's historically low status in China (15). The first published Chinese psychiatric classificatory scheme appeared in 1979. A revised classification system, named the Chinese Classification of Mental Disorders (CCMD-1), was made available in 1981 and was further modified in 1984 (CCMD-2-R). CCMD-2-R is viewed as an ethnomedical classification that covers symptoms and etiology, with the aim of conforming to international classifications while respecting cultural characteristics and diagnostic preferences. CCMD-2-R maintains an uncomplicated notion of depression ("depressive syndrome"), with no subclassification by type or severity, and retains *shenjing shuairuo* as a category.

The CCMD-2-R criteria for depression include a duration of symptoms of 2 weeks or more. The mandatory "core characteristic" is open to various English translations, but "low spirits" is perhaps the most appropriate. The criteria also include decline in social function and either distress or negative consequences for the individual, plus any four of following nine familiar symptoms of depression: lack of interest and anhedonia, anergia and fatigue without reason, psychomotor retardation or agitation, low self-esteem and self-blame or guilt, concentration difficulties, thoughts of death or suicidal behavior, insomnia or hypersomnia, poor appetite or weight loss, and a significant decrease in libido. Similarities to ICD-10 and to DSM-IV are evident. The relative acceptance of such a classification system might be expected to have an impact on the detection and diagnosis of depression and to encourage greater consistency in the data on depression originating in China and in the West.

Information From Acculturation Studies

Several studies have investigated whether the apparent low rate of depression in mainland China is also evident among "Westernized" Chinese populations. In general, rates of psychiatric hospital admissions for overseas Chinese are substantially lower than for other ethnic groups living in the same area (34, 35), but such differences may merely reflect variations in help-seeking behavior. In a community study of 1,747 Chinese Americans living in Los Angeles, the National Institute of Mental Health Diagnostic Interview Schedule was used to generate DSM-III-R diagnoses (36). The researchers found lifetime rates of 6.9% for a major depressive episode and 5.2% for dysthymia. The rate of major depression was substantially lower than

the general U.S. population rate of 17.1% established in the National Comorbidity Survey (5). Potential markers of acculturation, such as the language used and the length of residence in the United States, did not affect the rate of depression.

Such studies suggest that the prevalence of depression and rate of service utilization among Chinese residents in Western countries may be lower than those for the rest of the local population. However, definitive acculturation studies that could precisely distinguish racial and cultural factors would require the difficult task of recruiting subjects who were completely uninfluenced by their culture of origin.

Influence of Coping Factors

Xu (10) suggested that certain Chinese sociocultural factors provide some protection against becoming depressed. These might include a long-standing tradition of withstanding hardship, a high tolerance for distressing circumstances, a strong sense of interdependence with family and social support, and a sense of determination and purpose. Collective responsibility, morality, and emotional control may also be contributing factors (37). Such factors might not only reduce the tolerance to and recognition of personal distress in others, but also discourage help-seeking behaviors.

It has been proposed that Chinese people have a remarkable tolerance for depression, because socially reinforcing character traits such as quiescence and stoicism allow the individual to "accept" depression (38). Traditional cultural concepts with elements of "protective" fatalism (for example *mingyun* or fate or destiny) may have helped the Chinese to accept a predetermined life of stress and suffering. In addition, concepts such as *yuan* (predetermined affinity), *fengshui* (complex beliefs about the influence of physical surroundings), and *ren* (tolerance, including patience and forbearance) are all valued coping mechanisms (39). As a consequence, the distinction between "normal" and "pathological" states may be quite different than the Western threshold.

Sanctioned Expressions of Emotional Distress

Even before the introduction of the *shenjing shuairuo* concept, verbal expressions of emotional distress were not sanctioned in Chinese cultures. Somatization in symptom presentation is not due to a lack of a Chinese emotional lexicon (40), as the Chinese vocabulary is rich in terms that capture emotions. Instead, there are cultural preferences in the way that emotions are experienced and communicated, with bodily complaints judged as more socially acceptable than complaints of emotional distress. In a culture where "display rules" govern emotional expression, it is more acceptable to seek help for physical than emotional problems (41).

In Chinese societies, emotional messages are often conveyed not in words that designate emotions but rather through metaphors that are often related to the physical body (42). Symbols, gestures, and metaphors constitute a "language of emotions," and mutually understood somatic terms have affective meanings. For example, "heartache" conveys sadness, while "fatigue" or "tiredness" usually means hurt and despair (40). Kwong and Wong (43) confirmed that many verbal expressions of feelings in the Chinese language did not discriminate clearly between physical complaints and emotional distress. Zheng et al. (44) asked depressed subjects and comparison subjects to verbally express key emotional and physical terms from Western depression inventories and found that phrases to explain the word "depression" were frequently expressed somatically.

Somatization

The term "somatization" has several distinct meanings, and its usage is often ambiguous. In medical sociology and anthropology, the concept describes a pattern of illness behavior and a style or idiom of expressing distress in which somatic symptoms are presented to the exclusion of emotional distress (45). Kleinman (11) considered that neurasthenia was a culturally formulated type of somatization, as opposed to a somatization disorder. Somatic symptoms may be used as culturally acceptable metaphors to express "discomfort" in ways that are understood within the individual's social milieu but which may have quite different meanings to outsiders (46). On the basis of this definition of somatization, patients possess awareness of psychological symptoms (experienced alone or together with physical symptoms) but choose to present only somatic symptoms or somatic components of psychological symptoms when seeking help. Although its prevalence and specific features vary considerably across cultures, somatization in patients seeking help is universal, and somatic symptoms are the most common clinical expression of psychological distress worldwide (46, 47). Thus, this definition of somatization is distinct from the more traditional concept that the individual with somatization is unaware of any psychogenic cause of a physical problem.

Early studies suggested that the Chinese tended to complain of somatic symptoms and avoid seeking psychiatric help (45), although the lack of medical and social support services as well as political factors may have contributed to this tendency. Western observers often neglect the fact that, before the 1980s, high percentages of mainland Chinese were affected by anemia, hepatitis, hookworm, and a range of other debilitating physical problems that would have generated a background of true physical symptoms and fatigue. As somatization was reported to occur more

often among Chinese patients, it was assumed to be a Chinese cultural trait (45, 48) that was based on the suppression of emotions, a lack of distinction between the psychological and the physical, or constraints of the vocabulary (42).

Many studies have confirmed a preference by depressed Chinese people to report somatic features. For example, Chang (40) identified differing patterns of depressive symptoms on the Zung Self-Rating Depression Scale for white and black American college students and overseas Chinese students. The black subjects' responses were characterized by a mixture of affective and somatic complaints and the whites' by existential and cognitive concerns, while responses by the Chinese students emphasized somatic complaints. Tsoi (49) studied 120 consecutive Chinese patients who had received a diagnosis of either anxiety or depressive neurosis at a psychiatric outpatient clinic in a Singapore general hospital. In the patients' responses to a checklist of symptoms, "general discomfort" was the most frequently checked category, followed by "pain," "insomnia," "anxiety," "depression" and "autonomic symptoms."

In a study by Chan (50), euthymic Hong Kong Chinese medical students and nurses completed a word association test for the word *you-yu* (meaning "depression"). Chan suggested that the subjects' extensive use of external referents reflected a tendency for indirect expression of feelings—perhaps reflecting a concern with emotional restraint and with not imposing one's feelings on others (51).

Studies of "neurotic" and "depressive" Chinese outpatients have found that the patients typically complain initially of physical symptoms such as insomnia or headache, but that further questioning usually identifies emotional and social problems (19, 51, 52).

Lin (19) argued that the apparent overrepresentation of somatic symptoms in depressed Chinese might reflect inadequate depression measures. To address the lack of appropriate measures, Lin devised the Chinese Depressive Symptom Scale on the basis of research with community residents from Tianjin. It had been suggested that Chinese respondents may be willing to affirm psychological symptoms when provided the opportunity to do so. Lin concluded that open-ended questions evoked a flood of somatic complaints but that appropriate structured questions appeared to yield appropriate responses about psychological symptoms.

Thus, somatization within the Chinese context does not appear to be a conscious denial of emotional distress, but a culturally determined idiomatic cognitive style that is an initial "negotiative tactic" (24) and not necessarily maintained on further questioning. Attributing more distress to physical than to psychic symptoms is a significant cultural tradition of Chinese people. This tradition influences help-seeking behaviors and symptom reporting and allows Chinese people to avoid the stigma attached to mental disorder, but it also leads to overreporting of physical symptoms or the selection of physical symptoms as the first symptoms to report.

The Stigma of Mental Illness

Mental illness is stigmatized in traditional Chinese culture, as in many parts of the world. It is seen as evidence of weakness of character and a cause for family shame, a "collective loss of face" for the extended family (53). The family may deny a family member's mental illness, while fear that others may find out about mental illness in the family may prevent the family from obtaining adequate outside help (54). The stigma of depression is likely to have reduced the identification of the illness in both community surveys and clinical settings.

Hegemony, Diagnostic Fashion, and Nosological Relativism

Healy (55) has reminded us when the antidepressants were discovered in the late 1950s, pharmaceutical companies were unsure about whether they should be commercially released, because the relevant "market" was judged to be small. At the time, "depression" was used to describe an illness that required hospitalization. In subsequent decades, Western estimates of the lifetime prevalence of depression have increased as the term has come to embrace not only major depression but also many variants of minor and brief depression and even subclinical and subsyndromal expressions.

In a context of evolving definitions of depression, do the Chinese deny or minimize "depression," or do Western cultures reframe and elevate some expressions of human distress to "disorder" status? Both tendencies probably exist: the Chinese may be prone to minimize the experience of depression (as defined by the West), while Western cultures may excessively "pathologize" aspects of human experience.

Conclusions

Depression appears to be less evident in the Chinese and more likely to be expressed somatically, as a result of a rich set of interconnecting influences. Processes that have contributed to this tendency over recent decades include:

1. A low level of reporting of depression owing to the stigma of insanity, imputations of "weakness of character," political influences, and the view that emotional illness is "part of life."

2. Idiomatic reporting of distress and illness behavior factors that reflect the Chinese epistemology of disease, a language of emotions linked to physical symbols and metaphors, a tendency to report of distress along a conduit of somatization, and the cultural popularity of concepts such as neurasthenia and *shenjing shuairuo*.

3. Issues of detection and identification, including the lack (until recently) of a criterion-based classification sys-

tem that adopts Western concepts and diagnostic decision rules and the presence of a higher threshold for considering a response to life's stressors as pathological.

4. Factors that protect against depression, including coping mechanisms such as quiescence and stoicism, family and cultural support systems, and a lower level of urbanization than in the West.

The expression of many such factors has changed significantly since the early 1980s when the traditional culture of mainland China began to change rapidly. As the Chinese become more psychologically minded, affective expression will almost certainly gain legitimacy (24) and have a considerable effect on the expression and identification of depression.

This review of the literature clarifies a key clinical issue. If depressed Chinese patients are more likely to somatize their distress, then Western clinicians may be concerned that they may not have the capacity to detect and diagnose depression in Chinese patients. The data suggest that, irrespective of the symptoms that they initially volunteer, truly depressed patients may be expected to admit to depressive symptoms when the interviewer moves beyond open-ended questions to more specific questioning.

Reviewing the evolution of concepts of depression among the Chinese provides a useful opportunity to reflect on the way the illness has been identified and treated in Western cultures and on how rapidly the definition and meaning of depression have evolved in the last few decades.

Received Nov. 1, 1999; revisions received April 10 and Oct. 18, 2000; accepted Nov. 17, 2000. From the School of Psychiatry, University of New South Wales, Sydney, Australia; the Mood Disorders Unit, Prince of Wales Hospital; and the Institute of Mental Health, Singapore. Address reprint requests to Dr. Parker, Mood Disorders Unit, Prince of Wales Hospital, Randwick 2031, Sydney, Australia; g.parker@unsw.edu.au (e-mail).

Supported by the Institute of Mental Health, Singapore, and by program grant 993208 to the Mood Disorders Unit from the Australia National Health and Medical Research Council.

The authors thank colleagues at the Institute of Mental Health, Singapore, for constructive comments; Dr. Sing Lee, Dr. Michael Phillips, Dr. Heather Brotchie, Dr. Tony James, and Mrs. Kerrie Eyers for assistance; and Dr. Hong Wei Wang and Dr. Wei Wen for translation of study materials.

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