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The Etiology of Neurasthenia in Chinese-Americans, its Effect on Help-Seeking Behaviors, and Paths for a More Culturally Competent Future

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INTRODUCTION

Depression can significantly impair overall functioning and the global prevalence of this debilitating disease is increasing every year (Suang & Tohen, 2002); by 2020, depression will be second only to heart disease in accounting for the world's disease burden (WHO, 2009). Depression is associated with the one of the highest rates of mortality and disability out of all chronic health conditions (WHO, 2009). However, there is a cultural group that seems to be immune to the growing prevalence of depression: the Chinese. On the whole, the Chinese have a much lower depression rate when compared to other populations. According to the Chinese American Psychiatric Epidemiological Study (CAPES), Chinese immigrants and their second generation descendents in the United States have a 12-month depression rate that is a third of the national average (Takeuchi, 1998). These findings suggest that Chinese-Americans are inherently a happy and stable population which has somehow been able to avoid depression's debilitating symptoms, as outlined by the Diagnostic and Statistical Manual (DSM). However it is important to note that the DSM, which delineates the criteria by which depression is diagnosed, is used primarily by a Western psychiatric circle. The DSM symptoms of depression, while an effective means for diagnosis in the United States for mainstream American citizens, are not universal. Just because the Chinese do not satisfy all the criteria for depression as defined by the DSM, does not mean that they do not suffer from obstacles similar to those caused by depression. Chinese Americans are not exempt from the global pattern of escalating prevalence of depression; it is because of the mistranslation of Chinese depression symptoms into the language of Western biomedical systems and the differences between Chinese and Western modes of appropriate behavior that the CAPES study identified so few Chinese Americans with depression.

The CAPES study was well structured and researchers intended to use it to learn more about the "health and well being" of the considerable Asian population in America, which will triple by 2025 (Takeuchi, 1998, p. 1407). The study was conducted in English, Mandarin, or Cantonese on a randomly selected 18-65 year old member of each of the 1,747 Los Angeles based Chinese-American households that qualified for the study. The diagnostic instrument used was the DSM III-R, and the interviewees were screened for major depression episodes and dysthymia, a chronic but less severe form of major depression. The results for the major depression episodes were striking; the

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Mental Disorder		Rate in Chinese- American Adults (CAPES)	Rate in National Sample of Adults (NCS)
Major Depressive Episode	Lifetime	6.9%	17.1%
	12-month	3.4%	10.3%

Figure 1: Showing the disparities between Lifetime and 12-month major depressive episode rates between Chinese-Americans and the national American population according to the CAPES and NCS surveys.

lifetime rate was 6.9%, and the 12 month prevalence rate was 3.4% (see Figure 1). These results were in unusual contrast when compared to the results of the National Comorbidity survey, which assessed the overall United States lifetime major depressive episode rate at 17.1% and the 12 month prevalence rate at 10.3% (Takeuchi, 1998). The study implies that the Chinese population in America is a secure and a content population which is nominally affected by the obstacles presented by immigration.

THE CHINESE CONTEXT

In contrast to the Chinese population's apparent immunity to immigration stress, Chinese adages regarding leaving their homeland reveal their wary attitudes towards immigration. "An tu chung chien" advises one to "dwell contentedly on one's native soil, unwilling to be moved from [one's] native place," and "Lo yen kuei ken" recommends that people should return to their homeland, just as "the leaves fall and return to the root" (Chu, 1972, p. 319). Obviously the Chinese greatly value their native culture and these proverbs imply that immigration is unwise. This outlook on leaving one's native soil conflicts with the CAPES data, which suggest that immigration difficulties have little effect on the Chinese-American population. Psychiatric disorders occur more often among immigrant populations because of the change in culture. The strain that results from this change is proportional to the literal and figurative distance between the cultures (Yeh, 1972). Because there is such a large difference between many of the social constructs in China and the United States, the migration from China to the United States is exceptionally difficult. This shift in environment leads to "confusion of value orientations, difficulty in communication, psychological isolation, and increased uncertainty concerning the self and its relation to others" (Yeh, 1972). The stress caused by these conflicts between self and society manifests into psychiatric disorders like depression.

Although immigration to a radically different environment and culture is widely acknowledged as a distressing process, the CAPES results still resonate with popular perceptions of the Chinese in America. It is common knowledge that immigration is destabilizing, but still the stereotype of the unemotional Chinese persists. In a study conducted in the United States, Chinese-American students were asked to identify traits they associated with their Chinese-American peers. Among the characteristics deemed "more Chinese than American" were cautious, distant, serious, reserved, formal, and stable (Yeh & Chu, 1974, p. 209). These traits reflect unfeeling behavior, devoid of both highs and lows emotionally. It seems rational that a population that considers itself distant and stable would not be affected by an emotional disease such as depression. In accordance with the Chinese-Americans' perceptions of themselves, when non-Chinese Americans were asked to identify traits aligning with Chinese-Americans' social style, they listed traits such as stoic and uncompassionate (Oyserman & Sakamoto, 1997). If both emic and etic perspectives of the Chinese-American culture see the Chinese population as aloof and removed from emotional matters even if they have gone through the stressful process of immigration, it seems plausible that this population, socially or biologically, is immune to emotional disorders like depression. However, these perceptions of the Chinese American community are superficial. The behavior and values of the Chinese population does not serve to confirm the results of the CAPES study because behaviors have different meanings in different cultural contexts. Just because an individual does not exhibit the key emotive characteristics of depression as defined by the DSM-IV, does not mean that they are indifferent or unresponsive to distressing situations. Expressing a 'depressed mood' or 'low self-esteem' to society or even a psychiatrist is not universally appropriate. It is risky to extrapolate stereotypes or popular perceptions to rationalize mental health phenomena.

Similarly, extrapolating 'depression' from 'suicide' is not universal; while suicide may be a good indicator of a depressed individual in the West, suicides do not always correlate with instances of depression in China. However, suicide in China does suggest intolerable pressure or extreme dissatisfaction with one's life (Hsieh & Spence, 1981). The current suicide rate in China is 23.2 out of every 100,000 individuals (Phillips & Zhang, 2002), which is 7 more individuals per 100,000 people than the global average, and 12 more individuals than the United States average (WHO, 2009). This markedly high suicide rate in China is inconsistent with the image of the stable, unemotional Chinese population living in the United States, which reinforces the fact that Western perception of a concept, like suicide, does not universally connote the same circumstance, like the DSM diagnosable depression. China's suicide prevalence seems like a contradiction: the Chinese are not depressed but they are still committing the radical act of suicide. This apparent paradox is explained because the Chinese, when suffering from similar circumstances that lead the mainstream American population into depression, undergo a different illness experience. For the Chinese, it is not emotional disorders like depression, but somatic illnesses that were more frequently associated with suicide (Lin, Kleinman, & Lin, 1981, p. 247)

A somatic illness is a primarily physiological illness experience. Neurasthenia is a somatic illness characterized by "bodily weakness, fatigue, tiredness, headaches, dizziness, and a range of gastrointestinal and other complaints" (Kleinman, 1986, p 22). Neurasthenia was originally made popular by American neurologist George Beard in 1868, and he had coined it the "American Disease" (Kleinman, 1986, p16). Ironically, a century later, Neurasthenia is essentially nonexistent in the United States, but accounts for nearly a third of all 'psychiatric' diagnoses at Hunan Medical College in China. However, it is important to note that the physicians at Hunan Medical College and their patients may disagree about categorizing Neurasthenia as a psychiatric disorder. The etiology of Neurasthenia can be described in purely physiological terms. Neurasthenia in China is called "Shen jing shuai ruo" and several aspects of its nosology are described in its name. Shen is "spirit", and jing are the channels through which the vital energy, qi, runs. Shen jing, when together, means nervous system. Shuai means "degenerate" and ruo means "weak", so that shen jing shuai ruo is a condition of nervous weakness and inability to to transmit qi throughout the body (Lee, 1994, p. 153-154). The lack and imbalance of qi causes a disharmony of vital organs and generates the trademark symptoms of Neurasthenia (Parker, Gladstone, & Chee, 2001).

SOCIAL AND POLITICAL ETIOLOGY OF NEURASTHENIA

Depression is the most widely diagnosed mental illness in the West, Neurasthenia is the most widely diagnosed mental illness in China. Even though Neurasthenia was once the "American Sickness" (Kleinman, 1986), it has waned in Western biomedical systems and flourished in the Chinese mental health services. Depression, on the other hand, made up only 1% of the diagnoses in prominent Chinese mental hospitals (Kleinman, 1986). The reason neurasthenia in China was able to avoid a fate similar to being banished to the appendix of the DSM-IV, as it did in the West, has to do with the political and social context of the illness.

The first mention of a depression-like illness in Chinese medical literature was in the early 7th century when a "prolonged crying syndrome" (Kleinman, 1986, p43) was described. It depicted an illness during which a person's crying was so intense that qi becomes deficient in the body, which aligns easily with the modern concept of neurasthenia. Through its name, the prolonged crying syndrome seems to focus on emotional aspects of the illness but the Cultural Revolution shifted the values of Chinese psychiatry. The Cultural Revolution transformed the diagnoses of mental illnesses, as psychiatry is the "reflection of objective reality, the concrete conditions of social life" (Kleinman, 1986, p 30). Neurasthenia was introduced to China when Chinese psychiatry was still in its beginning stages (Ming-Yuan, 1989). Unfortunately, the progress of Chinese psychiatry was immobilized when the Cultural Revolution, an era of social and political upheaval, occurred (Kleinman, 1986). The government's closed door policy kept Chinese psychiatry secluded from innovation in the field from overseas. Mao Zhedong declared that psychology was "90 per cent useless and that the remaining 10 per cent was distorted and bourgeois phony science" (Kleinman, 1986, p 859). Depression had been branded "wrong political thinking" because in the context of China's "aroused political energy", depression connoted suspicious "disaffiliation and alienation" (Kleinman & Kleinman, 1985, p. 440). With this disapproval of psychology, it is logical that depression was not widely diagnosed in China during the Cultural Revolution. The legacy of Mao's sentiment continues today when few

individuals are diagnosed with depression. These conditions of psychiatry's seclusion and repression allowed for the condition of neurasthenia to thrive in a "uniquely Chinese psychiatry that combined biomedicine with indigenous approaches" (Kleimnan, 1986, p. 34).

There were few Western biomedical physicians during the Cultural Revolution, and because the handful that did practice Western biomedicine were primarily engaged in combating infectious diseases; illnesses characterized by abnormal behavior, like neurasthenia, were left up to those practicing traditional Chinese medicine. Neurasthenia was corresponded with kidney or heart weakness, and the inability of the nerves to transmit qi. Likewise, the Cultural Revolution is seen as depriving the entire social foundation of qi (Ware & Kleinman, 1992). Chinese neurasthenics often attributed their condition to being victimized by oppression during the Cultural Revolution, or by being disillusioned after their dedication to the revolutionary ideals (Ware & Kleinman, 1992). Dizziness, a symptom of neurasthenia, symbolized estrangement from the body, social constructs, and politics. Neurasthenia was a way to "[justify] withdrawal from stressful situations" and avoid "being sent down to the countryside" (Ware & Kleinman, 1992, p. 556) without the implications of depression.

Political prejudices against depression and psychiatric disorders in general coalesced with the paradigms of Chinese stigma. The Chinese have often been characterized as "experts at keeping harmony with their environment" (Yeh & Chu, 1974, p. 200). This discernment is not an accident, but rather a result of structured training from childhood emphasizing compliance with the socially acceptable standards. A Chinese child is "trained to control emotions that are considered adverse and disruptive to harmonious social interaction", and punishment of boisterous behavior is a salient characteristic of Chinese teaching techniques which accounts for "the learning of self-control and emotional restraint at an early age" (Tseng & Wu, 1985, p. 10). While excessive displays of emotions are strictly discouraged, these rules do not mean that the Chinese disallow all expression. Sickness is accepted and physical ailments are addressed. If a child conveys stomach pain, he or she "will be given warm soup to eat and tenderly cared for, while a child who expresses fear will probably be scolded" (Hsu, 1985, p. 105). The interactions between Chinese children and their elders reflect priorities and expected behaviors for a Chinese individual not just in childhood, but also when the individual assumes full adult roles in his or her interactions with society.

Behaviors taught during a young age carry into adulthood and the teachings of Confucius are heavily emphasized when first learning the modes of socially appropriate behavior. Confucian thought, which teaches methods for maintaining harmony with society, has "never ceased in its influence on Chinese society" (Tseng & Wu, 1985, p10). This continuing line of philosophy accounts for the reservation and emphasis on conformity in the Chinese code of conduct by advocating "inhibition and avoidance of emotional expression" (Lin, 1981, p. 102). Confucian traditions shape values and expected behaviors of the Chinese in society and also affect related social experiences like managing mental illness symptoms. The Chinese are trained "not to respond to hazardous stimuli with excessive emotions" (Lin, 1981, p. 102), which exhibiting symptoms of depression will violate. Thus, the Confucian philosophical tradition "legitimates suppression as a psychoculturally adaptive coping mechanism" (Lin, 1981, p. 102), and demonstrates why emotional symptoms of an illness may be deemphasized and the somatic symptoms amplified. Neurasthenia is an opportune illness when considering these social expectations because the patient reacts to stressful situations in a suitable, physical way. Symptoms like joylessness would be stifled and manifested into bodily complaints such as fatigue. A Chinese individual has laudable character if they are "sober-minded" and "reasonable" (Weizhen, 1985, p. 54), but looked down upon if they were "sad;" sadness could potentially pose a burden on friends and family. Somatized ailments do not affect disposition and do not impede harmony or the projection of admirable character.

In Chinese culture, posing a burden on others is deeply frowned upon, and one's actions not only influence the individual's image, but the image of the family. The Chinese concept of collective responsibility has deeply ingrained influence on an individual's behavior, as the family's appearance is inseparable from each member of the family. An individual's conduct represents "the collective qualities of the family, including the faults or virtues of the ancestors" (Hsu, 1985, p. 99). This means that any display of mental illness is a consequence of a family member having done something immoral. Illnesses are expected to affect the body, but if the illness has undesirable emotional effects such as gloominess or antisocial behaviors, the family is held responsible. This may be because physical ailments are clearly linked to biology, but psychological ailments can be attributed to factors in the environment. These standards may lead to repression of expressive be-

haviors because they would encumber family members with the duty of concealment and also suggest the family member had erred morally, causing the negative display of emotion. The dedication to "harmonious relationships in Asian cultural values" (Abe-Kim, Takeuchi, Hwang, 2002, p 1186) further underlines the reasons that somatization is present in Chinese medical systems.

The values enforced by the political background of psychiatric stigma and the emphasis on Confucian harmony within society and family taught during childhood carry overseas. These principles are ingrained deep within the Chinese immigrant population; these values do not dissolve into mainstream American standards. When asked to rate statements such as "I would be embarrassed if my friends knew I was getting professional help for an emotional problem" (Fogel & Ford, 2005, p. 472), Asian Americans had greater stigma beliefs than non-Asian Americans in all categories that were analyzed: friends, family, and employers. This reinforces the concept that Asians in America have retained their convictions on appropriate interpersonal behaviors, and that stigma is still influenced by traditional Asian values. When Chinese-American children were presented two pictures: one depicting a group of children who were similarly dressed, and the other depicting a group of children who had varied clothing, 93% of the children wanted to join the group with uniform clothing. This was in marked contrast to the Chinese-American children's non-Chinese American peers, out of whom only 41% chose to join the group of children with uniform clothing (Wilson, 1974). This demonstrates how deviating from a uniform, cohesive unit is discouraged in the population of Chinese-American children from a very early age, just like in China. These studies show that the social reasons for Neurasthenia's prevalence as a diagnosis in China also apply to the Chinese-American population because Chinese Americans have similar attitudes towards the Confucian code of conduct and towards stigma regarding mental health.

CHINESE PERSPECTIVES ON PURELY PSYCHOLOGICAL ILLNESSES

Just as the reasons behind the continued success of Neurasthenia in China resonate within Chinese Americans, so too do the norms of physician-patient behavior. Beyond stigma paradigms, the Chinese culture has established certain behaviors that are appropriate during patient doctor interactions. The Chinese population clearly presents physical symptoms to physicians because the physicians are able to diagnose these patients with neurasthenia based on the described symptoms. However, because of stigma, different illness experiences, or appropriate modes of doctor-patient behavior, emotional symptoms are not as widely reported. "Amplifying somatic distress and silencing affectivity... may simply reflect the norms and values of the health care system" (Lee, 1997, p 116). While this may suggest that the Chinese patients are manipulating the physicians by presenting what they believe is more urgent, it also may mean that the physicians are expecting physical symptoms to construct their diagnosis. Somatization was sparked by of the social and political background in Chinese culture, but it proliferates because it is advantageous in a clinical setting. Somatization is not an intentional rejection of emotional symptoms, but a "culturally determined idiomatic cognitive style that is an initial negotiative tactic" (Parker, et al., 2001, p 862). This reminds us that although illness is not an enjoyable experience, there are benefits to being ill, such as exemption from work and other stressful situations. Accentuating somatic ailments is a "locally appropriate strategy of engaging physicians' concern" (Lee, 1997, p. 116). To get more substantial treatment, higher priority symptoms may be emphasized. The Chinese are not ignorant of purely mental disorders, but "patients report somatic symptoms to professionals because they are what professionals think are important" (Ying, 1990, p. 394). It is not within the Chinese doctor-patient interaction archetype to discuss feelings and expect attention or desired treatment. Emotional symptoms are underreported to physicians "in response to perceived situational demands" (Cheung & Snowden, 1990, p. 285).

Although the Chinese are not unaware of psychological symptoms, and it is possible that many of them cater their symptoms to what they believe will yield the best treatment, it is evident that physiological symptoms accompany psychological ones in the Chinese mental health paradigm. Because of the concept of organs relating to disposition in traditional Chinese medicine, when a patient is experiencing psychological ailments and knows that his problems are emotional, his or her "attention is thereby channeled to preoccupation with the alleged physiological function of the related bodily organ" (Lin, 1981, p. 102). It is reasonable that much of the attention to bodily organs in Chinese mental healthcare is not a denial of psychiatric illness or a patient's manipulation of the physician, but a belief of actual issues with the associated organ. The organ may actually be functioning abnormally because of lack of

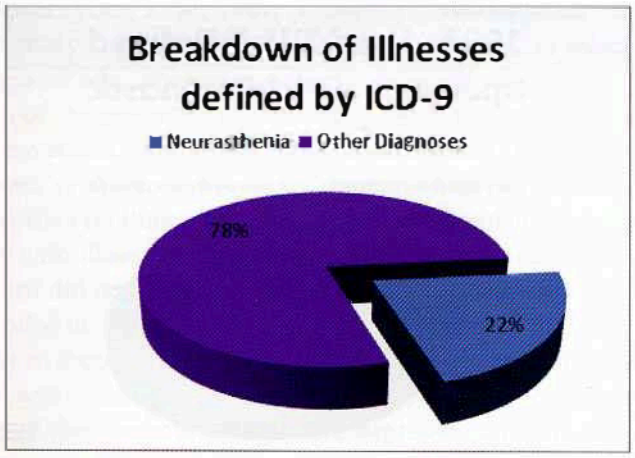
or accumulation of qi, or the discomfort in the organ may be because of the patient's ideas. Regardless of what the truth is, all neurasthenic patients believed that "their problems were primarily physical" (Kleinman & Kleinman, 1985, p. 439). The Chinese ideas of somatization should not be dismissed because it is those concepts that create the illness, and therefore the shape the illness experience.

IS NEURASTHENIA REDUNDANT?

The value of catering to patient's expectations versus abiding by strict diagnostic criteria was investigated when two psychiatrists had independently diagnosed forty patients with Neurasthenia. The symptoms were then systematically analyzed using different diagnostic criteria. When using the ICD-9, 22.2% of the patients were diagnosed with Neurasthenia, and other diagnoses ranged from anxiety to depressive neurosis (Ming-Yuan, 1989). No patient was left without a diagnosis (see Figure 2). This suggests that Neurasthenia may be over diagnosed by Chinese psychiatrists who are using the ICD criteria loosely. They may be catering to the patient's expectations, or their diagnosis may be informed by their experience and norms in Chinese psychiatry. However, Neurasthenia was not an option when using the PSE/CATEGO diagnostic tools. When using the PSE/CATEGO system, the percentage of patients diagnosed under other treatments increased, as the patients diagnosed with Neurasthenia were spread among other categories, but no diagnosis was made for 15% of the patients (see Figure 2). The study therefore lends a conclusion besides the main one the researchers highlighted. While the academics who conducted the research emphasized the overdiagnosis of neurasthenia, their study also showed neurasthenia's integrity as a recognized diagnosis. This means that neurasthenia, as a formal category, has its flaws. It may be diagnosed too often by Chinese psychiatrists, because of cultural norms. Also, Neurasthenia may encompass symptoms from other illnesses, and that there are cases that are interchangeable between Neurasthenia and mental illnesses. However, the study also validates Neurasthenia as a category because it accounts for 15% of the illnesses that were not able to be diagnosed when Neurasthenia was not an option. In a widely cited study in 1982, Kleinman reclassified 87% of Chinese Neurasthenic patients as cases of Major Depression according to the DSM III, even though the patients "suppressed most of the affective symptoms" (Kleinman & Kleinman, 1985, p. 436). This suggests that Neurasthenia is a result of poor diagnostic criteria and ill-defined ontology, and that diagnoses are too easily influenced by the patients' expectations (see Figure 3, page 28). This report was delved into again 15 years later with the same 1,747 interviews conducted in Chinese-American households in Los Angeles. In this study, out of the Neurasthenic patients identified by ICD-10 criteria, 56% of them experienced "pure Neurasthenia" that did not overlap with any lifetime DMS-III category. The researchers found that only 27.7% of those with Neurasthenia had symptoms that overlapped with Major Depression (see Figure 3). This is in contrast to Kleinman's initial theory, and implies two thoughts. First, the results of the studies may differ because Chinese psychiatrists have acknowledged overuse of Neurasthenia in the past, and the system of the 1997 study used "well-defined operationalized diagnostic criteria and structured interviews" (Zhang, Takeuchi, & Lin, 1997, p. 254). Secondly, it signifies that even when strict categorization is used, "pure Neurasthenia" was still the most prevalent disorder among the Chinese-American population. This challenges the theory that Neurasthenia is a "masked" form of depression and that Neurasthenia is just a façade to be ignored.

A similar, more qualitative study conducted in 1994 found that 54% of their Neurasthenic patients could be reclassified under "somatoform disorders" in the DSM-III-R, but found that the category did not "capture Neurasthenic patients' variegated symptom profile" (Lee, 1994, p. 164). In addition, they found that Neurasthenia had similar symptoms to Depression, but differed from depression in the patient's primary complaint. This demonstrates that if coerced to, Neurasthenia can be reclassified under other labels. However, these labels are not nearly as effective as having the diagnoses Neurasthenia available because "somatoform disorder" only provides a snippet view of the patient's whole illness experience. If depression is applied on a Neurasthenic patient, treatment will address the primary complaints of depression, even though it is the somatic complaints that are important to the patient.

Studies on the overlap of Neurasthenia with DSM disorders concede that there is substantial overlap between Neurasthenia and symptoms of other disorders, and that it is likely that Chinese psychiatrists have over diagnosed depression in the past. However, they also suggest that Neurasthenia on its own is a legitimate category; it is different from other disorders in its primary complaint and psychiatrists undermining somatic symptoms to insist upon psychological ones would distance their patient.



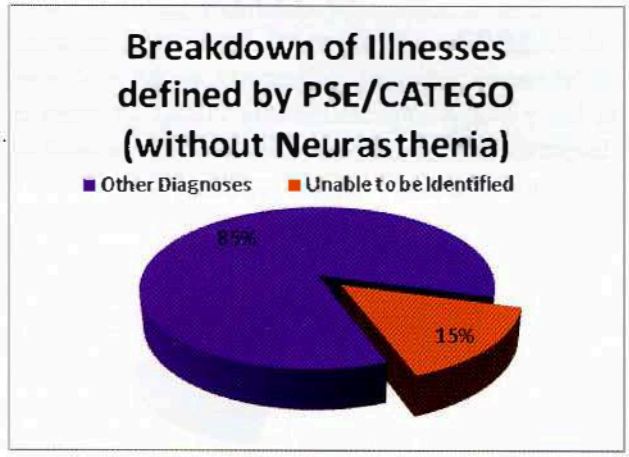


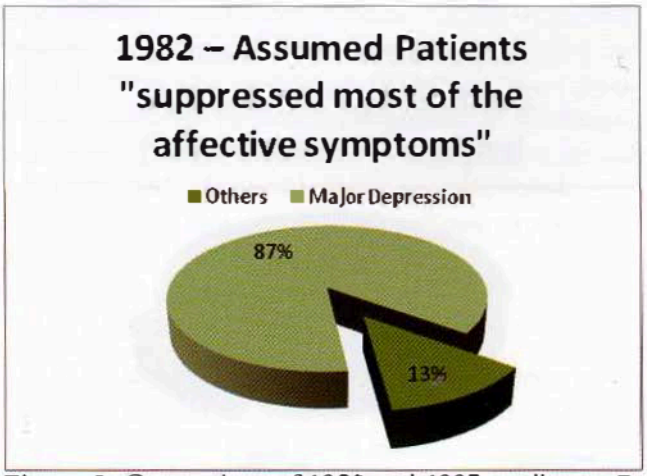
Figure 2: Comparison of the different diagnostic systems used on 40 patients that were independently diagnosed with Neurasthenia by two separate Chinese physicians. The results using ICD-9, which includes Neurasthenia as a possible diagnosis, and using PSE/CATEGO, which does not include Neurasthenia, are shown.

CHINESE-AMERICAN HELP-SEEKING BEHAVIORS

The Chinese' attention to physical symptoms, in conjunction with stigma, affect which, if any, resources they utilize to aid them in dealing with mental health issues. The Chinese culture's close-knit family results in them using family members for support first. Emotional disturbance is not associated with disease in Chinese culture, and therefore the Chinese do not see the need to visit professionals if there is no disease (Parker, et al., 2001). To illustrate this, a vignette of the story of Mrs. Wu, an immigrant who has a stressful lifestyle and purely psychological symptoms which meet the DSM depression criteria, was presented to Chinese Americans. Out of the 30% who described her as having neurasthenia, three-quarters suggested she get professional help. Out of those who believed she had a psychological problem, over two-thirds advised her to solve the problem within her family or by comforting herself. While this may be an effective method of treatment within an extensive support system, Chinese-American immigrants do not necessarily have this family network in the United States. This demonstrates the importance of allowing the Chinese population their own illness experience. If the clinician recognizes the Chinese-American's symptoms as a legitimate way of coping with stress, he or she should present interventions in a way that fits the patient's somatic explanatory model, because this is "pivotal in the client's willingness to accept the diagnosis, to remain in treatment, to adhere to the prescribed intervention, and finally, to recover" (Ying, 1990, p. 394). If a Chinese-American is neurasthenic, and their illness model is endorsed, he or she is likely to seek and uphold professional help. If the Western concept of depression is imposed on the same individual, with all the contexts and connotations associated with it in the Chinese culture, they are likely not to use resources they could benefit from.

The Chinese are underutilizing medical services available to them, and often do not commit to long-term treatment which may be required to properly address their psychosomatic illnesses. It is well documented that Asian-Americans use less mental health services (Cheung & Snowden, 1990). Half of all Asian Americans who do gather the resources and momentum to visit the vastly unfamiliar setting of Western mental healthcare end up leaving after a single session (Sue, 1997). This demonstrates the incongruity of Chinese and American norms when tackling health issues, and stresses that cultural competency needs to be addressed.

The vast difference between the style of those practicing traditional Chinese medicine and Western practitioners presents another barrier to healthcare utilization by Chinese-Americans. The Chinese-American population is used to behaving differently and expecting different behaviors from medical enviromnents compared to what the Western clinical setting entails. Within the Chinese community, mental health advice generally aligns with the patient's ideal solution, patients are able to give gifts to the medical authority, and this practitioner is allowed to form personal relationships with the patient (Sue, 1997). With



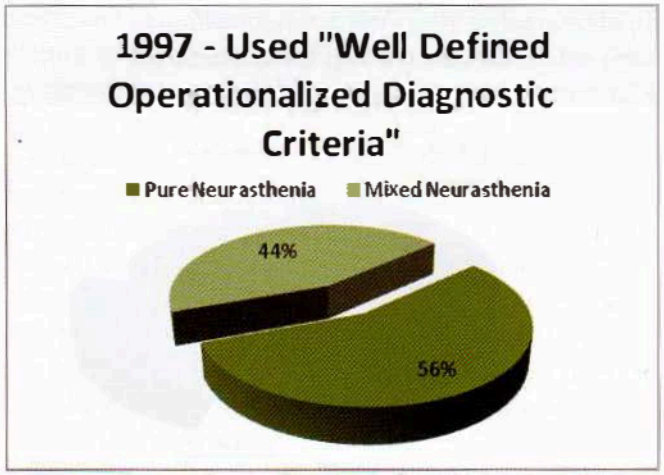


Figure 3: Comparison of 1982 and 1997 studies on Reclassification of Neurasthenia, in which the prior eliminated Neurasthenia as a possibility, and the other acknowledged both DSM illnesses and Neurasthenia as viable.

mental health professionals outside the Chinese community, treatment is often a prescription that differs from the patient's expected or preferred resolution, a gift exchange system is embarrassing for the professional, and the professional can only form neutral, technical relationships with the patient (Sue, 1997). These differences can be an obstacle to a Chinese-American individual's comfort within a clinical setting. A change in mode of conduct can be destabilizing and confusing; Chinese-Americans "do not share the values of Western mental health providers" (Ying, 1990, p 395). When the professional's advice does not agree with the patient's judgment, it is likely that the patient will terminate follow-ups or seek advice elsewhere. The formality of mainstream American doctor-patient relationships can make the Chinese-American patient feel ignored and dehumanized, especially if the patient is used to exchanging gifts with the medical authority. With these differences in mind, the Asian American underutilization of mental health resources is understandable.

WHAT WESTERN HEALTHCARE PROFESSIONALS CAN DO

The Chinese-American population would benefit from less stigma towards psychiatric services so that they start treatment earlier and recover from mental illnesses through continued efforts from a healthcare provider. In a study conducted on Chinese-Americans' perceptions of others' stigma beliefs, the Chinese-Americans were found to hold strong stigma beliefs and intense fear of rejection based on their mental illnesses even though few actually experienced a negative response in connection with their mental illnesses. While about two-thirds of those questioned in the study agreed that others characterized them as "untrustworthy" and "dangerous", only 11% believed they may have actually been treated differently on the basis of their mental illness by healthcare professionals. To address this, healthcare professionals need to emphasize that the actual attitudes of those who interact with the mentally ill are not as intolerant of the mentally ill as the Chinese-American population believes. Mental health specialists need to paint a better picture of what happens when an individual is diagnosed with a mental illness, and how others view those who have mental illnesses.

Besides stigma, there are other obstacles that a Chinese-American must tackle within the Western healthcare setting, like the insular attitudes of some physicians. Categorizing a neurasthenic individual with depression is largely ineffective and an ethnocentric practice. Although it is the role of Western psychiatrists to diagnose the patient, the patient must be made comfortable with the diagnosis. If a patient is simply assessed and prescribed medication without explanation, it is an imposition of Western labeling. The categorization of patients into different illness roles has significant repercussions in the clinical setting because a patient's illness experience is an important part of recovery. If a Chinese-American individual is suffering from Neurasthenia, psychiatric counseling will not help to fully address their somatic complaints. Even if the root of the disease is psychiatric, "when physiological functions are disturbed, the logical methods of treatment become physi-

ological" (Lin, K-M, 1981, p. 102). This is demonstrated in a study conducted on Neurasthenic patients, in which they were administered antidepressant drugs. Even though 87% of the patients experienced "slight" to "substantial" improvement, very few saw improvement in family, school, or work problems (Kleinman, 1986). This "limited effect on illness behavior and social problems associated with illness" (Kleinman, 1986, p440) is because the patient did not feel his or her neurasthenic ailments were attended to. Out of the 87% of patients who saw improvement in their condition, only 11% said their initial condition was depression at their follow-up appointment, even though they were told they were depressed and that their medication was an anti-depressant (Kleinman, 1986). This study reveals the crucial role a patient's perception of their own illness plays in their recuperation. The diagnosis and treatment must be made clear; physician transparency is essential to a patient's full recovery, especially when the patient is in an alien mode of healthcare.

A step towards accommodating the population of Chinese-Americans, which is rising in magnitude, visibility, and influence on mainstream American culture, would be to include Neurasthenia in the DSM V. However, Western psychiatrists are reluctant to include Neurasthenia because they feel it is not well documented enough and that it may distract psychiatrists from making the correct diagnosis:

> "The recent position of American psychiatrists might be epitomized by the DSM-IV Options Book, the forerunner of the DSM-IV. This states that "the availability of this diagnosis may lead clinicians to use it as a waste basket category, resulting in their overlooking other mental disorders [e.g., Major Depressive Disorder] and nonpsychiatric medical conditions [e.g., anemia].. Because of the lack of empirical research supporting Neurasthenia, it is unlikely that this disorder will be included as a separate category in the official classification." (Lee, 1994, p. 155)

This demonstrates how Neurasthenia is regarded as a "lesser" disorder that is not up to the standards of Western psychiatry. The large Neurasthenic population that has been diagnosed and successfully treated by educated Chinese physicians does not seem to yield evidence that is dependable enough for Western psychiatrists. As for the claim that Neurasthenia will become a "waste basket category", this is unlikely because of the contrast of Western doctor-patient interactions with the Chinese model: there is no cultural context leading to overdiagnosis of Neurasthenia among Western psychiatrists. Even if Neurasthenia were used to diagnose illnesses that didn't fit under anemia or Major Depressive Disorder, not only would it be more culturally appropriate, but would yield far better treatment than a DSM diagnosis that is lumped under the broad "somatoform disorder" category, or worse, "not otherwise specified."

CONCLUSION AND IMPLICATIONS

The CAPES data found a very low prevalence rate among the Chinese-American population in Los Angeles when compared to the national average. This rate is not a misrepresentation and is not inaccurate; the Chinese-American population is less depressed than the mainstream American population when their illnesses are assessed according to the DSM III-R. This implies that despite Chinese attitudes towards leaving their homeland, and despite the stresses and obstacles associated with immersing oneself in a drastically different culture and environment, the Chinese do not yield to the anxiety and do not become ill. Although the emic and etic stereotypes of the stoic and unflappable Chinese-American agree with this misconception, suicide rates in China reveal that the Chinese are considerably affected when struggling through stressful experiences. However, the repression of psychiatry during China's political upheaval, Confucian traditions emphasizing inhibition, conformity and maintaining face, and the importance of filial relations dissuading posing a burden on family, all intensified the stigma towards expression of psychological distress. The shame associated with mental illnesses caused patients to amplify their somatic symptoms because it is what physicians were seeking, and because their attentions were directed towards the physical ailments. Neurasthenia is important in Chinese culture because it leads to Chinese-Americans getting treatment sooner from a medical system that is foreign to them. If practitioners in the Western biomedical system scoff at the patient's explanatory model of Neurasthenia, it only adds to the mountain of barriers against the Chinese-American using Western mental healthcare.

It is unfortunate that although Neurasthenia is a very real illness for Chinese and Chinese-American patients, many Western psychiatrists do not believe its validity. Some psychiatrists have the opinion that neurasthenia "stands in the way of psychiatric progress" (Kleinman, 1986, p. 21). It is clear that those who have this opinion are not inspired by interactions with those suffering the somatic

consequences of distressed lives. A patient's genuine belief that he or she is suffering from fatigue, dizziness, and other bodily complaints because strain has weakened their channels for distributing qi is enough to debunk neurasthenia as an impediment to psychiatry's progress. Even if the patient's explanation for his or her illness is a culture-bound belief, it does not undermine the symptoms the patient is experiencing. Perhaps to some psychiatrists, neurasthenia is "a meaningless concept" (Kleinman, 1986, p. 21), but to Chinese and Chinese-American patients, neurasthenia has the profound meaning of being a culturally appropriate outlet for symptoms relating to stress. Just because the Chinese-Americans aren't depressed, their somatic symptoms should not be dismissed because the depression itself is a background-specific syndrome and should not be imposed on those unfamiliar with the DSM's culture.

REFERENCES

Abe-Kim, J., Takeuchi, D., & Hwang, W. (2002). Predictors of Help Seeking for Emotional Distress Among Chinese Americans: Family Matters. Journal of Consulting and Clinical Psychology, 70(5), 1186-1190.

Alvarez, A., Juang, L., and Liang, C. (2006) "Asian Americans and Racism: When Bad Things Happen to "Model Minorities"." Cultural Diversity and Ethnic Minority Psychology 12.3: 477-92.

Becker, J., and Kleinman A., (1991). (Eds.) Psychosocial aspects of depression. Hillsdale, N.J: L. Erlbaum Associates, 1991.

Chan, M. F. (2003). "Attitudes of Hong Kong Chinese to traditional Chinese medicine and Western medicine: survey and cluster analysis." Complementary Therapies in Medicine 11: 103-09.

Cheung, F., & Snowden, L. (1990). Community Mental Health and Ethnic Minority Populations. Community Mental Health Journal, 26(3), 277-291.

Cheung, F. (1987). Conceptualization of Psychiatric Illness and Help-Seeking Behavior Among Chinese. Culture, Medicine and Psychiatry, 11, 97-106.

Chu, H-M. (1972). Migration and Mental Disorders. In Lebra, W. (Ed.), Transcultural research in mental health. (pp. 296 - 325). Honolulu: University of Hawaii, 1972.

Chung, K., & Wong, M. (2004). Experience of stigma among Chinese mental health patients in Hong Kong. Psychiatric Bulletin, 28, 451 - 454.

Fogel J, & Ford D. (2005). Stigma beliefs of Asian Americans with depression in an Internet sample. Can J Psychiatry (Revue Canadienne de Psychiatrie) 50 (8):470– 8.

Gotlib, I., and Hammen, C. (2008). (Eds.) Handbook of depression. 2nd ed. New York: Guilford.

Harmsworth, K., & Lewith, J. (2001). Attitudes to traditional Chinese medicine amongst Western trained doctors in the People's Republic of China. Social Science and Medicine 52: 149-53.

Hsieh, A., & Spence, J. (1981). Suicide and the Family in Pre-Modern Chinese Society. In A. Kleinman, & T-Y. Lin, (Eds.), Normal and abnormal behavior in Chinese culture. (pp. 29-48). Dordrecht: D. Reidel, sold and distributed in the U.S.A. by Kluwer Boston.

Hsu, J. (1985). Family Relations, Problems, and Therapy. In W-S. Tseng, & D. Wu (Eds.), Chinese culture and mental health. (pp. 95 – 112). Orlando: Academic.

Kleinman, A, & Good, B. (1985). (Eds.) Culture and depression studies in the anthropology and cross-cultural psychiatry of affect and disorder. Berkeley: University of California.

Kleinman, A. (1980). Patients and healers in the context of culture an exploration of the borderland between anthropology, medicine, and psychiatry. Berkeley: University of California.

Kleinman, A. (1986) Social origins of distress and disease depression, neurasthenia, and pain in modern China. New Haven: Yale UP.

Kleinman, A., & Kleinman, J. (1985). Somatization: The interconnections among culture, depressive experiences, and the meanings of pain. A study in Chinese society. In Culture and Depression, eds. A. Kleinman & B. Good, pp. 132-167. Berkeley, University of California Press.

Lee, S. (1997). Chinese Perspective on Somatoform Disorders. Journal of Psychosomatic Research, 43(2), 115-119.

Lee, S. (1998). Estranged Bodies, Simulated Harmony, and Misplaced Cultures: Neurasthenia in Contemporary Chinese Society . Psychosomatic Medicine, 60, 448-457.

Lee, S. (1994). The Vicissitudes of Neurasthenia in Chinese Societies: Where Will It Go From the ICD-10?. Transcultural Psychiatry, 31, 153-172.

Lin, K-M. (1981). Traditional Chinese Medical Beliefs and Their Relevance for Mental Illness and Psychiatry. In A. Kleinman, & T-Y. Lin, (Eds.), Normal and abnormal behavior in Chinese culture. (pp. 95-114). Dordrecht: D. Reidel, sold and distributed in the U.S.A. by Kluwer Boston.

Lin, K-M., Kleinman, A., & Lin, T-Y. (1981). Overview of Mental Disorders in Chinese Cultures: Review of Epidemiological and Clinical Studies. In A. Kleinman, & T-Y. Lin, (Eds.), Normal and abnormal behavior in Chinese culture. (pp. 237- 272). Dordrecht: D. Reidel, sold and distributed in the U.S.A. by Kluwer Boston.

Lin, T., et al. (1978). Ethnicity and Patterns of Help Seeking. Culture, Medicine and Psychiatry, 2, 3-13.

Ming-Yuan, Z. (1989). The Diagnosis and Phenomenology of Neurasthenia. Culture, Medicine and Psychiatry, 13, 147-161.

Oyserman, Daphna, and Izumi Sakamoto. (2001). Being Asian American: Identity, Cultural Constructs, and Stereotype Perception. Journal of Applied Behavioral Science 33.4: 435-53.

Parker, G., Gladstone, G., & Chee, K. (2001). Depression in the Planet's Largest Ethnic Group: The Chinese. American Journal of Psychiatry, 158, 857-864.

Phillips, M., Li, X., & Zhang, Y. (2002). Suicide Rates in China. Lancet, 359, 835-840.

Schwartz, P. (2002). Why is Neurasthenia Important in Asian Cultures?. Western Journal of Medicine, 176, p257-258.

Suang, M., and Tohen, M. (2002) (Eds.) Textbook in Psychiatric Epidemiology. New York: Wiley-Liss

Sue, S. (1997). Community Mental Health Services to Minority Groups. American Psychologist, 1, 616-624.

Tabora, B., & Flaskerud, J. (1994). Depression Among the Chinese: A Review of the Literature. Issues in Mental Health Nursing, 15, 569-584.

Takeuchi, D. (1998). Lifetime and Twelve-Month Prevalence Rates of Major Depressive Episodes and Dysthymia Among Chinese Americans in Los Angeles. American Journal of Psychiatry 155(10),1407-1414.

Tata, S., & Leong, F. (1994). Individualism-Collectivism, Social-Network Orientation, and Acculturation as Predictors of Attitudes Toward Seeking Professional Psychological Help Among Chinese Americans. Journal of Counseling Psychology, 41(3), 280-287.

(2009). The global burden of disease: Depression. World Health Organization. Retrieved October 21, 2009, from http://www.who.int/mental_health/management/depression/definition/en/

Tseng, W.-S., and Wu, D. (Eds.), (2008). Chinese culture and mental health. Orlando: Academic, 1985.

Walker, C. (2008). Depression and globalization : the politics of mental health in the 21st century. New York: Springer.

Ware, N., & Kleinman, A. (1992). Culture and Somatic Experience: The Social Course of Illness in Neurasthenia and Chronic Fatigue Syndrome. Psychosomatic Medicine, 54, 546-560.

Weizhen, S. (1985). A Preliminary Study of the Character Traits of the Chinese. In W-S. Tseng, & D. Wu (Eds.), Chinese culture and mental health. Orlando: Academic.

Wilson, R. (1974) The Moral State: A Study of the Political Socialization of Chinese and American Children. New York: Free Press

Yeh, E-K. (1972), Paranoid manifestations among Chinese students studying abroad: some preliminary findings. In W. Lebra, (Ed.), Transcultural research in mental health. (pp 326 – 340). Honolulu: University of Hawaii.

Yeh, E-K., & Chu, H-M. (1974). The Images of Chinese and American Character: Cross-Cultural Adaptations by Chinese Students. In Lebra, William P., ed. Youth, socialization, and mental health. (pp. 200-216). Vol. 3. Honolulu: University of Hawaii.

Ying, Y., & Miller, L. (1992). Help-Seeking Behavior and Attitude of Chinese Americans Regarding Psychological Problems. American Journal of Community Psychology, 20(4), 549-556.

Ying, Y. (1990). Explanatory Models of Major Depression and Implications for Help-Seeking Among Immigrant Chinese-American Women. Culture, Medicine and Psychiatry, 14, 393-408.

Zhang, Y., Takeuchi, D., Lin, K., et al. (1997). Epidemiological Study of Neurasthenia in Chinese-Americans in Los Angeles. Comprehensive Psychiatry, 38(5), 249-259.