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Illness Beliefs of Depressed Chinese-American Patients in a Primary Care Setting

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I. Introduction

Asian-Americans are the fastest growing minority population in the United States, with their population tripling in the past twenty years. During the last decade, it grew by 44% to the current 10.1 million (in 2000), comprising 4% of the U.S. population.[1] The growth rate is expected to continue, and by 2020, Asian-Americans are projected to make up 6% of the nation's population. It is increasingly important for clinical practitioners to understand the illness beliefs regarding mental disorders of this group of diverse populations.

Early cross-national studies concluded that Asians tend to have lower rates of depression than other ethnic groups.[2] However, more recent studies in Asian countries have provided evidence to suggest that depression is more prevalent among Asians than previously considered.[3,4,5] Between 1998 and 1999, our group conducted a two-phase epidemiological survey in the primary care clinic of a community health center serving less acculturated Asian-Americans in Boston, Massachusetts. The survey found that the estimated prevalence of Major Depressive Disorder (MDD) among Asian-Americans in this primary care setting was 19.6 %± 0.06, suggesting that MDD is common among Asian-Americans in urban, primary care settings.[6]

In this chapter, we will focus on the illness beliefs of Chinese-Americans, who comprise 24 percent (2.4 million) of the Asian-American population and form its largest ethnic subgroup. In a recent study, our group investigated the illness beliefs of Chinese-American immigrants with MDD in a primary care clinic, exploring their chief

complaints, the labels they used for their illness, their experience of stigma, perceived etiologies, and the types of treatment sought for their depressive symptoms. These findings will help us understand the challenges of treating MDD among Asian Americans, and provide empirical evidence on possible approaches to improve the recognition and treatment of MDD among this population. We will also discuss the impact of culture on illness beliefs of depression, and assess whether the theoretical framework used by modern psychiatry is applicable to other cultures.

II. Conceptions of illness among depressed Asian-Americans

According to the Surgeon General's report (2001),[7] Asian-Americans have the lowest rate of mental health service utilization of any ethnic group in the United States. The undertreatment of depression among the Asian-American population has been attributed to a number of different causes, including the lack of recognition of depression among this population, stigma leading to non-treatment, and somatization.[8]

In European and North American cultures, depressive symptomatology, when meeting certain criteria, are viewed as part of the psychiatric syndrome of MDD, characterized by specific affective, cognitive, behavioral, and somatic symptoms. However, the interpretation of depressive symptoms varies across cultures, and leads to different ways of understanding the experience of negative, sad feeling states. Arthur Kleinman, a psychiatrist who also trained as an anthropologist, asserts that different cultures have different "explanatory models" of distress that define what is considered illness, the nature of symptoms, the appropriate treatments for any given symptom, and the kind of

relationships within which treatment takes place.[9] It may surprise many Western-trained mental health clinicians that in many non-European cultural groups, including the Chinese, Japanese, Southeast Asians, and Canadian Eskimos, concepts of depressive disorders equivalent to MDD are not found. [10]

When experiencing depressive symptoms, Chinese-Americans typically do not describe their distress in terms easily recognized by Western mental health practitioners. Oftentimes, their complaints are seen as "somatizing," disregarding obvious depressive states. One reason for this apparent disregard may be the stigma that is attached to psychiatric symptoms in Chinese culture, compared to the relative acceptance of physical complaints. In a study of primary care patients in Hunan, China in the 1980s, Kleinman found that depressed Chinese patients usually presented with somatic rather than mood symptoms.[9] He suggested that somatic symptoms were the more appropriate "idioms of distress" in Chinese culture, in which the designation of mental illness usually refers only to stigmatized psychiatric disorders such as psychosis and mental retardation.[11] Absent the psychodynamic influences of Freud and his successors in the West, there has been no tradition of treating depressive or anxious states within the purview of psychiatry amongst the Chinese. Being labeled as psychiatrically ill in China, whether for depression or another reason, risks being associated with those who are crazy or cognitively unsound, and being thought of in the same way.

Certainly, there is a powerful societal pressure in Chinese culture to suppress and disguise negative feeling states, and to avoid being associated with mental illness.[12,13,14] Other reasons for the high prevalence of somatization in Chinese populations, besides avoiding stigma, have been proposed.[1516] One possibility is that patients from non-

Western cultures and members of lower socioeconomic groups are less willing or able to express emotional distress.[15,17,18] Another may be their lack of familiarity with the Western psychiatric classification system of mental disorders.[3] From their study of primary care patients in Hong Kong, which also found that depressed Chinese patients complained primarily of somatic symptoms,[19] Cheung and her colleagues have suggested an alternative hypothesis: that the presentation of somatic symptoms among depressed Chinese patients may be a learned behavior to adapt to the norms of primary care settings.[20] With limited time for clinical encounters and practitioners' inclination toward a biomedical model, patients may surmise that physicians are more interested in physical, rather than psychological, symptoms. This is not surprising considering that a typical primary care visit lasts, on average, 5-10 minutes in many Asian countries.[†]

III. Illness beliefs of depressed Chinese-Americans in a primary care setting

A. Methods

Our team at the Massachusetts General Hospital Depression Clinical and Research Program has recently performed a study using a structured instrument to examine the illness beliefs of depressed Chinese-American patients in primary care.[21] The study took place at the South Cove Community Health Center (South Cove) in Boston, Massachusetts between May 1998 and November 1999. South Cove is an urban

[†] One of the authors (RK) witnessed an orthopedic surgery clinic in small hospital in Taidong, Taiwan, in the summer of 1994. The surgeon had arrived for his twice monthly 2-hour clinic, and had over 100 patients waiting. Averaging just over one minute per patient, this intrepid surgeon was helped by two nurses, one bringing in patients and having each sit in one of three chairs spaced about six feet apart. Each patient would have a brief moment, seconds at most, to share his most pressing concern, after which the doctor would give his clinical impression— that the wound needed redressing, that an antibiotic was indicated, that the patient had been delinquent in his wound care, etc.—shouting over the clamor to be heard. The second nurse would then jump in, carry out any directives, and discharge the patient before stepping a few feet over to attend to the next patient. The clinic ended on time. As one might imagine, there was neither the context nor the expectation that the patient share anything other than pressing somatic concerns.

community health center with wide-ranging clinical services that primarily serves low-income, Asian immigrants who face financial, linguistic, and cultural barriers to health care. In this collaboration with primary care physicians, 680 Chinese-American patients who sought care at South Cove were randomly approached and screened for depression using the Chinese translation of the Beck Depression Inventory (CBDI),[22] which has been previously validated by our group.[23] Fifty patients screened positive, and of these, 40 (8.0% of patients completing screening) were formally diagnosed with Major Depressive Disorder (MDD) using the Structured Clinical Interview for DSM-III-R, patient version (SCID-I/P).[24]

We approached those diagnosed with depression and asked them to participate in the next phase of the study, in which their illness beliefs would be elicited using the Explanatory Model of Interview Catalogue (EMIC).[25] The EMIC is a structured interview tool in which patients are probed about five dimensions of illness behaviors and beliefs: chief complaints, conceptualization and labeling of illness, perceptions of stigma, causal attributions, and help-seeking patterns. Twenty-nine (72.5%) of the 40 depressed patients agreed to be interviewed with the EMIC (see our published study for detailed methodology[21]). They included 18 females and 11 males, with a mean age of 46 years (SD= 15, range= 8 to 84), and a mean length of stay in the US of 6 years (SD 5.0, range = 1 to 12).

B. Results

1. Chief Complaints

The majority (N=22, 76 %) of the depressed Chinese-Americans complained chiefly of somatic symptoms. Among them, 12 (41%) presented with general physical symptoms,

and 10 (34.5%) presented with neurovegetative symptoms that are used as criteria for diagnosing MDD (e.g. sleep disturbance, marked weight loss or weight gain). The most common presenting complaints were fatigue (17.0%), insomnia (17.0%), headache (14.0%), cough (7.0%), pain (7.0%), dizziness (7.0%), cervical problems (3.4%), and sexual dysfunction (3.4%). Four subjects (14.0%) complained of psychological symptoms of depression, including irritability (7.0%), ruminations (3.5%), and poor memory (3.5%) (Table1). Two subjects (7.0%) described feelings of nervousness, but none complained spontaneously about depressed mood. One subject attended the primary care clinic for his annual physical examination and did not spontaneously report any health concerns. The profiles of depressive symptoms endorsed by patients based on the CBDI are described in Table 2. Interestingly, 27 patients (93%) endorsed depressed mood even though none of them reported depressed mood as their chief complaint.

2. Conceptualization and labeling of illness

When patients were asked to label their condition, over half (55%) reported "I don't know," 5 (17%) responded "not a (diagnosable medical) illness," and 5 (17%) attributed their symptoms to pre-existing medical problems. Most of the patients (n=26, 90%) did not ascribe their symptoms to depression or any other psychiatric condition. The remaining 3 patients (10%) thought that they suffered from a psychiatric disorder, including one who labeled himself as having "post-traumatic stress syndrome" (Table 3). When asked if they agreed with a diagnosis of Major Depressive Disorder as indicated by the SCID-I/P, 14 (48%) reported that they had never heard of the diagnosis (Yeung A. Effectiveness of cultural consultation on the willingness for treatment among depressed Chinese-Americans, unpublished data). When asked how the symptoms affected them,

26 patients (90 %) felt that the symptoms affected their mind, and 23 patients (79 %) felt the symptoms affected their body. Twenty-two (76%) felt that the symptoms affected both their mind and their body, which is consistent with an integrated mind/body concept used in Traditional Chinese Medicine (TCM).

3. Perceptions of stigma

Most patients reported low levels of stigma (mean stigma score 7.0, SD=12, range 0-36). More than half of them (n=15, 52%) reported no stigma regarding their symptoms, and an additional 8 patients (28%) scored less than 12 (Figure 1). Patients with high stigma scores tended to have severe depression and/or psychotic symptoms.

4. Perceived Causes

Subjects were asked to endorse all factors that they considered to be causal in their condition. Reported causes included psychological stress and/or psychological factors (93%), magico-religious-supernatural factors (45%), medical problems (17%), traditional beliefs (14%), hereditary (14%), toxicity (10.5%), and ingestion (7%)(Table 4).

5. Help-seeking patterns

Help-seeking strategies prior to seeking treatment at South Cove included using general hospital services (69%), seeking lay help (62%), using alternative treatments administered by clinical providers (55%), seeking spiritual treatment (e.g., faith healers, astrologers/palmists, praying) (14%), and self-administering alternative treatments (10%). Only one subject in the sample reported seeking mental health services (3.5%)(Table 5).

C. Illness beliefs about somatic symptoms and depression

With the use of the structured instrument (EMIC), the South Cove Study generated informative data on the different dimensions of how Chinese-Americans view depression and seek help for it. Consistent with results from previous studies,[13,26,27] a high proportion (76%) of depressed Chinese-Americans in the primary care clinic presented physical symptoms as their chief complaints. Only a small proportion (14%) of patients in this study presented with psychological symptoms including irritability, rumination, and poor memory. It is intriguing that none of the depressed patients in this study considered depressed mood as their chief problem when they were asked about their depressive symptoms. Yet, the majority of them had no problems reporting psychological symptoms using a standardized instrument. When assessed with the CBDI, over 90% of the subjects in this study did endorse having depressed mood, showing that they were aware of their depressed mood though they did not consider it their main problem. In additional to endorsing "feel sad," the depressed patients also reported many of the affective symptoms in the CBDI ("hopelessness" (59%), "failure" (79%), "no satisfaction" (76%), "guilt" (72%), "feeling being punished" (38%), "disappointed" (69%), "blame self" (86%), "suicidal (41%), and "irritability" (72%)). These findings argue against the hypotheses that Chinese patients suppress or are unable to express their feelings, are alexithymic,[28] or are lacking in emotional differentiation.[18]

Although depressed patients were able to recognize and report their sadness and other affective symptoms on the CBDI questionnaire, however, they did not consider affective symptoms their main problem or connect them with the label of a depressive illness. Over half of the subjects (n= 16, 55%) did not or could not give a name to describe their

condition, and an additional five patients (17%) did not believe that they even had a diagnosable medical illness. Five patients (17%) attributed their symptoms to prior medical illnesses, including the vague cause of "poor health." Out of the 29 subjects, 26 (90%) did not consider themselves as having a psychiatric disorder. Of the remaining three patients (10%), one believed he had PTSD and not depression, and the other two had unformed impressions of themselves as "crazy." Our findings suggest that Chinese-Americans interpret their depression symptoms differently from the Western psychiatric conception. In our study, they predominantly attributed their affective and somatic symptoms to stress/psychological factors, and did not consider depression a distinct disease entity.

IV. Cultural factors influencing the conceptualization of depressive symptoms

Psychiatric disorders are highly stigmatized in Chinese society.[29] Low stigmatization scores among many of the subjects from this study toward their symptoms provide further support that they did not consider their illness a psychiatric problem. In fact, when we asked the subjects about their understanding of depression, many of them reported that they had never heard of the term. Not conceptualizing their depressive symptoms as indicative of a psychiatric illness may be protective for depressed Chinese-Americans in a cultural context where mental illness is highly stigmatized. In the discussion below, we will try to explore how social and cultural factors may shape the Chinese understanding of depression symptoms, and the possible reasons for the divergence of the concept of depression between health professionals and Chinese-American patients.

Cross-cultural studies have informed us that each individual culture tends to have selective emphasis and presentation of emotional experiences. Based on an ethnographical literature review, Jenkins et al. illustrated the dramatic degree to which certain cultures may contrast with one another in the expression of feeling states. For example, while Eskimos and Tahitians seldom display angry feelings, the Kaluli of New Guinea and the Yanamamo of Brazil use quite elaborate and complex means of expressing anger.[30,31] In Western culture, emotional distress is often demarcated into relatively "pure forms" of anxiety and depression, though as Tseng notes, this differentiation into discrete "psych" and "soma" is arbitrary and not universal to all cultures. Many Chinese, for instance, manifest combined somato-mood presentations.[32]

Culture also influences the definition of selfhood. While individuals in Western, industrialized populations are characterized as unique, separate, and autonomous, individuals in non-Western populations are generally depicted in relational terms, as part of an interdependent collective, defined by kinship and myth.[30] People in the latter populations understand themselves as part of a living system of social relationships.[33] They are less likely to be introspective about feelings of subjective anguish or express individually-oriented, decontextualized self-statements of dysphoria (e.g., "I feel blue," "These things no longer mean anything to me") and worry (e.g., "I am bothered by things that usually do not bother me.").[34] Under the predominant influence of Confucianism, traditional Chinese society is a typical collectivistic culture. According to Confucius, certain interpersonal relationships, called the Five Cardinal Relations (*wu-lun*), are of paramount importance: those between ruler and subject, father and son, elder and younger brother, husband and wife, and friend and friend. Of these five dyads, three

belong to the family and the other two are based upon the family model. In Confucian social theory, the family occupies a central position–it is not only the primary social group, it is also the prototype of all social organizations.[35] In traditional China, there is no differentiation between social and political units, with the basic unit being not the individual but the family.[36] During the socialization process, children learn early on that they are to develop a dependent social orientation towards authority, and a group orientation toward the family. Within a group orientation, harmony within the family and society is primary; negative affects, rightfully or not, are considered undesirable or harmful to the social fabric, and as something to be mastered and blocked from overt expression as one matures.[9,37]

In tandem with Confucianism, Taoism is the other philosophy that has vastly influenced Chinese culture. Founded by the mythical figure of Lao-tzu, who may have been a contemporary of Confucius, Taoism avers that the essence of life is to learn to live with and imitate nature. Everything has its natural course. Distress is a part of life, not to be fought, but to be understood and to be harmonized with. This way of thinking has informed such Chinese practices as Tai-chi and acupuncture, as well as influenced the development of Buddhism. The Buddhist practice of meditation to isolate grief, fear, hostility, and negative affects, is readily understood within the Taoist framework. Meditation diminishes negative affects by facilitating the practitioner's becoming detached from them and transcending them in a mindfulness state. This is in sharp contrast with the Western psychological approach, which encourages emotional catharsis and intrapsychic exploration.[9]

The Taoist theory of Yin-Yang has also had enormous influence on the Chinese understanding of physiological functioning, and forms the pillar of Traditional Chinese Medicine. In Traditional Chinese Medicine (TCM), proper physiologic functioning is conceptualized in terms of balance and harmony, represented by the Yin-Yang schematic.‡ Every sign and symptom (including psychological ones since psych and soma are not split) is interpreted within Yin-Yang theory as an excess or deficiency of Yang, and the corresponding deficiency or excess of Yin; and every treatment modality is aimed at either enhancing Yang (or Yin), or eliminating excess Yang (or Yin).[38] TCM further characterizes physiological and pathological phenomena according to the Yin-Yang balance within the Five Phases (*Wu Xing*) of the body. The Five Phases and the corresponding organs are Wood (Liver), Earth (Spleen), Water (Kidney), Fire (Heart), and Metal (Lungs). The essences of each phase influence the functioning of various domains, from digestive functioning to emotional states, with each phase generating the succeeding phase (Figure 2).[39] The interconnection of these phases implies the unity of the mind-body, so that disparate symptoms such as chest pain, headache, sadness, and even psychosis are all seen as extensions of the same physiological framework. Practiced in China for thousands of years, TCM has had a strong influence on lay and folk concepts of illness, and on the language used to describe them.

The combined influences of Confucianism, Taoism, and TCM-based folk medical concepts, therefore, help explain why depressed Chinese-Americans selectively focus on and report somatic symptoms, minimize and under-report affective symptoms, and understand interpersonal tension as the cause of their distress. The reporting of physical

‡ The Yang is the strong, male essence; the Yin the yielding, female essence

symptoms is a more familiar and culturally appropriate way to communicate their distress than using psychological idioms to do so, which would be more familiar to patients from Western cultures. Within Western medicine, psychologization has long been considered the norm for symptom conception and presentation, and somatization deviant and a barrier to both the diagnosis and treatment of psychiatric disorders. Even within Western medical systems, however, the appropriateness of marginalizing somatization has been questioned. Simon et al. analyzed WHO data on psychological problems in general health care and found that more than 40% of depressed patients in centers all over the world presented initially with somatic complaints.[40]

Modern psychiatry is rooted in Western psychological existential idioms, and in disease classifications that are based on an intrapsychic orientation.[9] Such an orientation suits middle-class populations in the West, yet it does not generalize well to non-Western cultures, including the Chinese culture which tends to focus on physical symptoms and interpersonal relationship. This explains, in part, why ethnic minorities in the US and people in non-Western countries underutilize mental health services. Depressed patients who do not articulate psychological symptoms tend to be underdiagnosed by practitioners. To many Chinese patients, depression is an unfamiliar concept that does not fit well with their indigenous illness beliefs. As a result of their differences in the conceptualizing and labeling of symptoms, Chinese- and other Asian-Americans have limited access to mental health services. Educating people from non-Western cultures about the concept of depression would increase treatment and mental health care utilization, as would the broadening of current psychiatric classification systems to incorporate belief systems from other cultures. Cross-cultural research would be

extremely helpful in providing empirical support for this goal, as well as the data needed to implement such changes.

V. Implications for treating depressed Asian-Americans

The findings of our study have practical implications for treating Chinese-Americans with depression. The somatic presentation of depressive symptoms, so common among Chinese-Americans, has important public health implications since it often leads to the underrecognition and inadequate treatment of psychiatric disorders. Physicians commonly perform numerous unnecessary diagnostic tests and medical treatment to work up these physical complaints, which result in patient suffering, frustration among health professionals, and wasted resources.[41] Yet, our study shows that when depressed Chinese-Americans are asked explicitly, they readily report their depressive symptoms and have no difficulty doing so. Chinese-Americans tend not to complain of affective symptoms spontaneously. It seems apparent, then, that to better serve this less acculturated population, practitioners need to explicitly ask about the presence of depressive symptoms.

Treating Chinese-Americans, who often do not have an intuitive sense of depression as a clinically distinct diagnosis, and often attach stigma to any psychiatric diagnosis, presents another clinical challenge: to treat the patients without explicitly telling them that it is a psychiatric disorder, or to openly inform patients that they have a depressive disorder. The former approach may decrease stigma and be more acceptable to some patients, but could be seen as paternalistic and possibly disrespectful under Western societal standards. The latter approach assumes a more egalitarian doctor-patient relationship and allows

patients to make their own informed decisions, but may run the risk of increasing stigma and lead the patient to deny the illness or refuse treatment.

In the US, we do not have access to the diagnostic construct of "neurasthenia," a diagnosis embraced by patients and physicians in China during the 1980's as a way to avoid labeling patients with psychiatric diagnoses. Neurasthenia, much like the diagnoses of chronic fatigue syndrome and fibromyalgia, is a somatically-conceived illness with psychological symptoms, and may be a more culturally appropriate diagnostic category for Chinese-Americans than depression. Despite being limited to using depression as the only available diagnosis, however, we have not found it burdensome to introduce the concept of depression to less acculturated Chinese-Americans at South Cove. Our experience suggests that if the practitioner shows acceptance of patients' illness beliefs, the diagnosis of major depressive disorder is usually well received by Chinese-Americans. Furthermore, explaining depression using a more biologically-based model of neurotransmitter imbalances seems to fit well with Chinese concepts of balance, harmony, and somatically-based emotional symptoms. About half of the depressed patients in this study showed interest in receiving treatment for their depressive symptoms after we explained the Western understanding of depression and the treatments that are available.[42]

Although there may be advantages to introducing the Western concept of depression to patients, it is helpful to remain open to multiple explanatory models of illness. While the majority of depressed Chinese American patients presented with physical symptoms, most of them considered their illness to be caused by psychosocial stress associated with

personal responsibilities and interpersonal relationship. This highlights the importance of psychosocial treatment among depressed Asian-Americans. Treatment with medication alone, without alleviating personal and family tension, is less likely to be successful. In addition to psychological stress, close to half of depressed Chinese-American patients in this study considered magical-religious-supernatural factors (44.5%) and traditional explanations (14%) as causative factors. Many depressed Asian-Americans have used alternative treatment, particularly herbal remedies (55% in our study) to treat their symptoms. Kirmayer et al.[43] suggest using multiple explanatory models, including biomedical, psychological, religious, and traditional ones, to enhance communication with ethnic minority patients. In practice, clinicians should be receptive to the use of traditional forms of treatment, while at the same time monitoring possible side effects due to interactions between herbs and pharmacological agents.

Another strategy for enhancing the treatment of Chinese-American patients is working to integrate primary care and mental health services. The majority of patients in our study used general hospital outpatient services and lay help for treatment of their symptoms (Table 5). Only one subject (3.5%) in the study reported using mental health services for a chief complaint of depression. While many depressed patients seek help at primary care clinics, most of them remained undiagnosed and untreated for depression.[44] This is a serious public health problem that will only grow in magnitude, because Chinese-Americans are one of the fastest growing immigrant groups in the US. We have been testing an integrative service model to increase detection and treatment of psychiatric disorders inside primary care. It may reduce the stigma and bureaucratic barriers that arise in using mental health services. The preliminary results of a study of integrating

primary care and mental health services have been promising.[45] Yet, much more needs to be done to improve the delivery of psychiatric services to this highly underserved population.

VI. Conclusion

Depressed Chinese-Americans generally present with somatic symptoms in primary care. Nonetheless, when questioned explicitly about their symptoms, they often meet criteria for major depression. The lack of awareness of depression as a treatable illness, the influence of Asian philosophical and religious traditions, and the adoption of collectivistic social values may all contribute to their somatic presentation. Such illness beliefs may lead to the tendency of many depressed Chinese-Americans to seek help in primary care, under-report their mood symptoms, and under-utilize mental health services. It is important to keep an open mind and try to understand how they view their illness, and to accept their alternative explanatory models so that a mutually agreed upon treatment can be negotiated. Actively eliciting patients' mood symptoms, using culturally sensitive terminology in the explanation of MDD to minimize stigma associated with mental conditions, and integrating treatment of MDD into primary care settings may enhance recognition and treatment of MDD among Asian-Americans. In addition, incorporating illness conceptions from other cultures into the current psychiatric classification system may broaden its theoretical basis, and facilitate delivery of mental health services to people from non-Western cultures.

Table 1. Chief complaints of depressed Chinese patients (N=29)

Chief complaints	N (%)
Physical symptoms	12 (42)
Headache	4 (14)
Cough	2 (7)
Pain	2 (7)
Dizziness	2 (7)
Others	2 (7)
Depressive neurovegetative s/s	10 (34)
Insomnia	5 (17)
Fatigue	5 (17)
Depressive psychological s/s	3 (14)
Irritability	2 (7)
Rumination	1 (3.5)
Poor memory	1 (3.5)
Nervousness	2 (7)
Depressed Mood	0 (0)
No complaints	1 (3.5)

Table 2. Frequency of CBDI symptoms among depressed Chinese American patients (N=29)

Beck Symptom	Frequency(%)
1. Feel sad	27 (93)
2. Hopelessness	17 (59)
3. Failure	23 (79)
4. No satisfaction	22 (76)
5. Guilt	21 (72)
6. Feel being punished	11 (38)
7. Disappointed	20 (69)
8. Blame self	25 (86)
9. Suicidal	12 (41)
10. Crying	19 (66)
11. Irritability	21 (72)
12. Loss of interest	19 (66)
13. Difficulty making decisions	23 (79)
14. Look ugly	21 (72)
15. Can't work	23 (79)
16. Insomnia	23 (79)
17. Fatigue	28 (97)
18. Appetite loss	15 (52)
19. Weight loss	6 (21)
20. Hypochondriasis	26 (90)
21. Lost interest in sex	21 (72)

Table 3. Labels used by depressed Chinese patients to describe their illness (N=29)

Name of the illness	N (%)
"Don't know"	16 (55)
"Not an illness"	5 (17)
Medical illnesses (hypertension 1, cold 2, poor health 1, injured arm 1)	5 (17)
Post-traumatic stress syndrome	1 (3.5)
Mental illness or "craziness"	2 (7)

Table 4. Causes of illness perceived by Chinese patients (N=29)

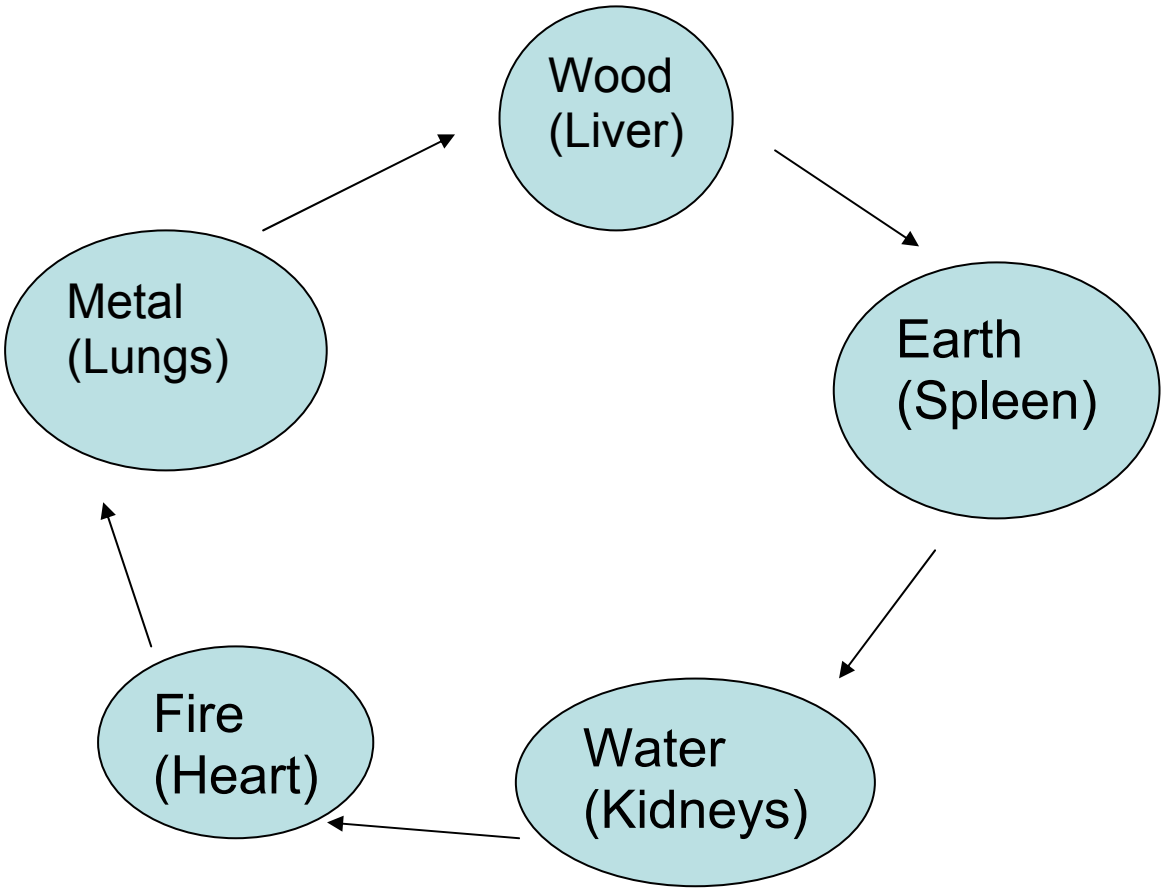
Methods	Frequency (%)
Psychological stress	22 (76)
Psychological factors	20 (69)
Magico-religious-supernatural	13 (44.5)
Medical problems	5 (17)
Traditional beliefs	4 (14)
Hereditary	4 (14)
Toxicity	3 (10.5)
Ingestion	2 (2)
Sex	0 (0)

Table 5. Methods of help-seeking by depressed Chinese patients (N=29)

Methods	Frequency(%)
General hospital	20 (69)
Lay help	18 (62)
Alternative treatment from others	16 (55)
Spiritual treatment	4 (14)
Alternative self-treatment	3 (10.5)
Mental health professionals	1 (3.5)

[See figure 1 in separate powerpoint file]

Figure 2. Mutual Control Order of the Five Phases



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