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Illness beliefs of Chinese American immigrants with major depressive disorder in a primary care setting

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ABSTRACT

Underutilization of mental health services in the U.S. is compounded among racial/ethnic minorities, especially Chinese Americans. Culturally based illness beliefs influence help-seeking behavior and may provide insights into strategies for increasing utilization rates among vulnerable populations. This is the first large descriptive study of depressed Chinese American immigrant patients' illness beliefs using a standardized instrument. 190 depressed Chinese immigrants seeking primary care at South Cove Community Health Center completed the Explanatory Model Interview Catalogue, which probes different dimensions of illness beliefs: chief complaint, labeling of illness, stigma perception, causal attributions, and help-seeking patterns. Responses were sorted into categories by independent raters and results compared to an earlier study at the same site and using the same instrument. Contrary to prior findings that depressed Chinese individuals tend to present with primarily somatic symptoms, subjects were more likely to report chief complaints and illness labels related to depressed mood than physical symptoms. Nearly half reported they would conceal the name of their problem from others. Mean stigma levels were significantly higher than in the previous study. Most subjects identified psychological stress as the most likely cause of their problem. Chinese immigrants' illness beliefs were notable for psychological explanations regarding their symptoms, possibly reflecting increased acceptance of Western biomedical frameworks, in accordance with recent research. However, reported stigma regarding these symptoms also increased. As Asian American immigrant populations increasingly accept psychological models of depression, stigma may become an increasingly important target for addressing disparities in mental health service utilization.

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1. Introduction

The tremendous personal, societal, and economic burden of depression is magnified among minority populations in the U.S., in part due to differences in rates of mental health service utilization (Alegría et al., 2008; Harman et al., 2004; Murray and Lopez, 1997; Virnig et al., 2004; Young et al., 2001). In particular, Chinese Americans have been found to greatly underutilize psychiatric services (Abe-Kim et al., 2007). A recent review suggests that the stubborn persistence of such racial/ethnic disparities in rates of utilization is likely attributable to multiple causes, including cultural variations in symptom expression and attribution, practical barriers, and underlying moderating factors affecting Asian Americans' experience and disclosure of psychological problems, such as stigma, shame, and emotion inhibition (Sue et al., 2012). Such conclusions add to a growing body of evidence derived from a variety of disease processes suggesting that culturally influenced illness explanatory models determine help-seeking behavior, selection of pathways to care, adherence to

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treatment, and satisfaction (Karasz et al., 2003; Kleinman, 1977; McCabe and Priebe, 2004; Office of the Surgeon General, 2001; Sussman et al., 1987). Some investigators have specifically recommended studying illness beliefs in order to address disparities in the utilization of mental health resources among ethnic and minority populations (Yeung and Kam, 2005).

Prior research in this area has consistently found that depressed patients of East Asian and South Asian cultural origin tend to emphasize somatic rather than psychological symptoms and favor interpersonal or contextual rather than biological explanations for their distress, as compared with their Western counterparts (Ekanayake et al., 2012; Karasz, 2005; Karasz et al., 2007; Kleinman, 1977; Yeung and Kam, 2005). Karasz has generalized this finding further to state that "non-Western, nonwhite, and non-middle-class individuals suffering from depression are more likely to exhibit somatic disturbances in medical settings than are Western middle class individuals" (Karasz et al., 2007). A variety of explanations for these findings have been proposed.

Early somatization models derived from psychoanalytic theories proposed that an emphasis on somatic symptoms represents a primitive form of psychopathology in which physical expressions of distress are substituted for emotional ones (Karasz et al., 2007). However, such "repression-based" explanations conflict with growing evidence that even among contemporary Western middle-class populations, depression often presents solely with somatic symptoms (Gureje et al., 1997; Jadhav et al., 2001; Piccinelli and Simon, 1997). The large and evidently common overlap between physical symptoms and psychological syndromes is unsurprising given that the diagnostic criteria for major depressive disorder (MDD) include disturbances in sleep, energy, and appetite.

Other investigators have proposed that Asian patients lack the ability to differentiate emotions (Leff, 1973) or are alexithymic (Le et al., 2002; Zhu et al., 2007). However, such hypotheses are contradicted by evidence that depressed Chinese and South Asian individuals readily report depressed mood when explicitly asked (Jadhav et al., 2001; Ryder et al., 2008; Yeung and Kam, 2005). In a large study comparing Chinese and Euro-Canadian subjects' performance on various measures of alexithymia, Dere and colleagues proposed that differences between the groups could be explained primarily by culturally based variations in the importance placed on emotions, rather than actual deficits in emotional processing in the Chinese group (Dere et al., 2012).

Kleinman, and more recently Kirmayer, suggested that apparent cultural differences in illness beliefs may be influenced by practical considerations. Kleinman proposed that somatization could be understood as one "idiom of distress" which, within a specific cultural context, is more likely to achieve personal goals—e.g. respite from work or resolution of family conflict (Kleinman, 1988). Under this framework, Chinese somatization could be understood as a matter of symptom emphasis rather than a completely different experience of distress (Ryder and Chentsova-Dutton, 2012). This theory, however, does not fully explain why members of a wide range of non-Western cultural groups with depression also primarily present with complaints of somatic disturbances.

Among immigrants, level of acculturation and education may also help shape illness explanatory models (Angel and Thoits, 1987; Karasz, 2005). For instance, given that the biopsychiatric disease model of depression is more common in Western societies (Keyes, 1985), Chinese immigrants' views regarding the cause of depressive symptoms would be expected to change from a physical "malady of the heart" to a psychological disease category as a result of increasing levels of exposure to American culture (Miller, 2006). Conceptualization of depression as a psychological illness is likely to also be influenced by other immigration and acculturation-related factors such as age of arrival, length of stay, and education (Jorm et al., 2000; Kuo and Roysircar, 2004; Parker et al., 2005).

To date, in-depth exploration of illness beliefs has been challenged by difficulty assembling sufficient sample sizes of study subjects from homogeneous racial/ethnic groups (particularly those with diagnosed depression), language barriers, and a lack of standardized research instruments. Reporting on the illness beliefs of an outpatient sample of 175 Han Chinese in Hunan and 107 Euro-Canadians in Toronto using adaptations of several scales, Ryder and colleagues found that patients from both populations reported depressed mood and sadness, and concluded that in the generation since Kleinman's work, "available cultural scripts for the presentation of emotional distress and social suffering appear to have changed markedly" (Dere et al., 2013). Inclusion in the study simply required participants to endorse "at least one core symptom of depression or neurasthenia," rather than to meet criteria for major depressive disorder.

Jadhav and colleagues also attempted a cross-cultural comparison in their study of the illness beliefs of 47 depressed Caucasian subjects in London and 80 Indian subjects in Bangalore using the Explanatory Model Interview Catalogue (EMIC) (Jadhav et al., 2001). Developed by Mitchell Weiss and first reported in 1992, the EMIC integrates research methods from epidemiology and anthropology to assess local representations of illness from the perspective of persons with a designated health problem (Weiss et al., 1992). Jadhav's group found that illness concepts were similarly diverse in both Caucasian and Indian populations, and that depressed Britons frequently reported somatic idioms of depression when specifically probed (Jadhav et al., 2001).

Karasz and colleagues performed one of the only studies to compare two different cultures occupying a similar geographic region in their survey of 37 married, upper middle-class European-American women from affluent New York City neighborhoods versus 35 married, working-class, non-English-speaking, South Asian women from an immigrant community in Queens, New York (Karasz et al., 2007). Utilizing a mixed-methods approach, they found that the South Asians group's illness representations correlated significantly less with a biopsychiatric scale, and significantly more with a situational scale, than did European Americans' (Karasz et al., 2007). However, the subjects in this study were not depressed, and the focus of the questions was on "medically ambiguous" rather than depressive symptoms. Similarly, Parker and colleagues compared explanatory attributions of Chinese-Australian and non-Chinese-Australian respondents regarding hypothetical symptoms such as fatigue, insomnia, and low appetite, though again participants were not themselves depressed (Parker et al., 2005).

Most of the prior research on illness beliefs of depressed Chinese individuals, including the work of Kleinman and Ryder, was conducted in China or Taiwan. One exception to this is Yeung and Kam's report on illness beliefs of Chinese American patients in Boston in 1998–9 using the EMIC, which found a predominance of somatic complaints and conceptualizations of depressive symptoms, though with a relatively small sample (Yeung and Kam, 2005). The purpose of the current exploratory study was to systematically characterize the illness beliefs of a large population of depressed Chinese immigrants identified through primary care using a semi-structured instrument, and to compare the results to Yeung and Kam's earlier report on a smaller sample from the same clinic site and utilizing the same instrument. Specifically, the EMIC queries patients about multiple dimensions of illness behaviors and beliefs: chief complaint, conceptualization and labeling of illness, perceptions of stigma, causal attributions, and help-seeking patterns. The EMIC has been previously validated among depressed individuals in diverse cultural contexts (Weiss et al., 2001). In line with recent research in this area (Dere et al., 2013),

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