INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction..

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

ProQuest Information and Learning
300 North Zeeb Road, Ann Arbor, MI 48106-1346 USA
800-521-0600

University of Alberta

Chinese Causal Beliefs and Help Seeking Preferences Concerning Depression

by

David Byron Sinclair 

A thesis submitted to the Faculty of Graduate Studies and research in partial fulfilment of the requirements for the degree of Doctor of Philosophy

in

Counselling Psychology

Department of Educational Psychology

Edmonton, Alberta

Spring 2000

University of Alberta

Library Release form

Name of Author: David Byron Sinclair

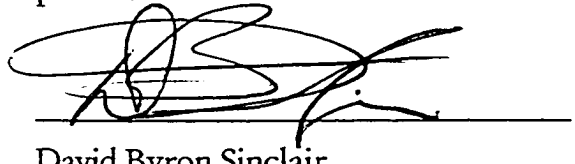
Title of Dissertation: Chinese Causal Beliefs and Help Seeking Preferences Concerning Depression

Degree: Doctor of Philosophy

Year this Degree Granted: 2000

Permission is hereby granted to the University of Alberta Library to reproduce single copies of this dissertation and to lend or sell such copies for private, scholarly or scientific research purposes only.

The author reserves all other publication and other rights in association with the copyright in the dissertation, and except as herein before provided, neither the dissertation nor any substantial portion thereof may be printed or otherwise reproduced in any material form whatever without the author's prior written permission.



David Byron Sinclair

3515-114 Street

Edmonton, Alberta,

Canada T5J-3B3

Date submitted: January 04/2000

University of Alberta

Faculty of Graduate Studies and Research

The undersigned certify that they have read, and recommended to the faculty of Graduate Studies and Research for acceptance, a dissertation entitled Chinese Causal Beliefs and Help Seeking Preferences Concerning Depression by David Byron Sinclair in partial fulfilment of the requirements for the degree of Doctor of Philosophy in Counselling Psychology.

Dr. L. L. Stewin

Dr. P. Calder

Dr. B. C. Paulson

Dr. R. H. Short

Dr. P. A. Saram

Dr. V. Pearson

Date Approved: 4/1/2000

This dissertation is dedicated to my wife Chen Suo,
and to my two sons Adam and Byron.
Without your hard work, love, patience and support
this work would not have been possible.

Abstract

This research addressed the causal beliefs about, and the help seeking preferences for depression, held by 676 Chinese lay people from four distinct groups (university, urban, rural and clinical), as well as the causal beliefs about depression held by 98 Chinese health care professionals. The influence of factors such as levels of depressive symptoms and clinical status on causal beliefs and help seeking preferences was also examined. The results indicated that the Chinese lay people and health care professionals surveyed in this study hold similar and sophisticated psychosocial causal theories of depression that resemble those held in the 'West', and that, in general, Chinese lay people favour psychosocial interventions and self-help in overcoming depression.

A factor analysis of the 26 causal attributions studied revealed seven clearly interpretable factors. These 'Causal Factors' were labelled; Biological/fatalistic, Environmental stress–downtrodden, Family problems, 'Lacks Inner Resources', Negative–depressing influences, Unfulfilled Aspirations and Poor Health/Environment. The Causal Factors receiving the highest endorsements in the aetiology of depression were ZLacks Inner Resources and 'Family problems'. A factor analysis of the 16 help seeking alternatives studied revealed four clearly interpretable factors. These 'Help Seeking Factors' were labelled; Traditional/Western medical, Supernatural/folk, Social support/self-help and Mental health professional. The Help Seeking Factors receiving the highest endorsements were 'Social support/self-help' and 'Mental Health Professional'. Strong positive correlations were found between the Causal Factors 'Biological/fatalistic' and 'Poor Health/Environment' and the Help Seeking Factors 'Traditional/Western medical' and 'Supernatural/folk'.

There was also a significant effect of the level of depressive symptoms and clinical status (whether or not subjects were in treatment for depression) on subjects' ratings of both causal beliefs and help seeking preferences. Weak, but statistically significant, correlations were found between the severity of depressive symptoms and the 'Supernatural/folk' and the 'Traditional/Western medical' help seeking factors. A moderate and negative correlation was found to exist between clinical status and the 'Family problems' causal factor. Clinical status was moderately and positively correlated with the Mental health professional and Traditional/Western medical help seeking factor.

The results are discussed with respect to understanding the nature and impact of causal models of depression on help seeking with a view to better targeting of interventions for depressed Chinese people.

ACKNOWLEDGMENTS

I wish to thank my mentor and friend Dr. Bruce Bain for his encouragement, support and guidance throughout the entirety of this dissertation. His steadfast belief in the importance and validity of my work was a continual reminder that I was doing something of value and making a significant contribution to the field of psychology. I am deeply indebted to Dr. Michael Phillips for his friendship, support and wisdom. His technical expertise and practical assistance, his encouragement and validation, were a bulwark against the moments of frustration and disillusionment, and an inspiration to create a more scholarly work.

My deep gratitude is due to Dr. Len Stewin for his support and encouragement of my academic and research efforts throughout the years and for stepping in to this process at a most difficult time; making the timely completion of this work possible. Drs. Peter Calder, Henry Janzen, Barbara Paulson and Paulusaramge Saram helped to define and refine the project into something valid and 'doable'. My sincere thanks to Drs. Rob Short and Veronica Pearson for consenting to sit on the examining committee and for providing their timely, thoughtful and helpful comments and criticisms which made the final product a better one. Drs. Anthony Marsella, Michael Harris Bond and Charles Spielberger provided insights and suggestions that were invaluable in conceptualising and targeting my investigations. I would also like to extend my thanks to Dr. Zheng Yanping for his pioneering work on depression in China and for developing the Chinese Depression Inventory that played such an important role in this research.

In China, my enduring thanks go to two eminent psychologists and educators Drs. Wang Lei, Wang Dengfeng, the learned and dedicated Mrs. Fang Xin and

Dr. Qian Mingyi and the many graduate students of the psychology department of Beijing University. They provided invaluable assistance in evaluating the questionnaires, facilitating their cultural and linguistic revisions both before and after the focus group process. They also provided logistical and institutional support without which the research would not have been possible.

Dr. Tang, his graduate students at the Beijing Medical University psychiatric hospital and all of the members of the Beijing Clinical Psychologists group, gave of their time and talents in all phases of the research. I would also like to thank all of the personnel at the Hui Long Guan county, and psychiatric hospitals, An Ding psychiatric hospital, Zhong Ri hospital, Hai Dian hospital, Guang An Men traditional Chinese medical hospital and the Hua Li counselling centre who participated in the data collection for the study.

A special acknowledgement of my gratitude is particularly due to my family, friends and all of the community volunteers in Beijing who reviewed the final questionnaires and made the collection of the community samples possible.

Finally, I would like to express my deepest gratitude to the hundreds of people who consented to participate in this research. The time and thoughtfulness with which they executed their part in the research was truly invaluable and constitutes the core of the current project. It is you for whom this research was conducted in the hope that whatever findings result from your efforts will ultimately benefit Chinese people suffering from depression in the future.

A NOTE ON THE PASSING OF A MENTOR AND FRIEND

Words cannot express my sense of loss after the untimely and tragic death of my good friend and mentor Professor Bruce Bain one week before we were to review a pre-defence draft of this dissertation. The world was enriched by your presence, and is all the poorer for your passing. I will miss you deeply and long, but your legacy will live on in me and in the many others whose lives you graced. .... 再 见 我的 大哥。

TABLE OF CONTENTS

LIST OF FIGURES

Chapter 1 - Introduction

For the thing which
I greatly feared is come upon me,
And that which I was afraid of
Is come unto me
I was not in safety, neither
had I rest, neither was I quiet;
yet trouble came.
- Job (3:25, 26)

Thus opens William Styrone's (1990) book 'Darkness Visible: A Memoir of Madness'. In this very poignant work Styrone detailed his personal struggle with depression. As one of the most skilled and accomplished wordsmiths of the 20th Century, Styron declared that he was unable to adequately convey the ravages of depression in his life and in the lives of some of his close friends and colleagues. For people suffering from depression and those close to them, this malady constitutes a major and potentially devastating life event.

Depression causes incalculable personal devastation and incurs exorbitant social costs. It can plunge families into despair and/or poverty, particularly if the principal sufferer is the primary breadwinner. Helping professionals who deal with depressed patients will attest to the zombie-esque transformation the disorder inflicts on its victims. Generally speaking, depression's ravages are proportional to the chronicity of the disorder. However, even in an acute 'first-episode' of depression the end result can be suicide. If suicide or spontaneous remission does not occur, and the depression is not properly treated, the first-episode can represent the point of departure on a long downward spiral

into chronicity. The paradox and promise resides in the fact that, while depression is a potentially catastrophic event, most cases are readily treatable with psychosocial and/or pharmacological interventions. The key lies in early and effective intervention in the form of education, diagnosis and appropriate treatment.

This raises the issue of how we facilitate early interventions. Early intervention requires a proactive stance. In order to be proactive, we need to understand when, where and how to intervene in the course of depression. To do this we need to understand the beliefs that average people hold about the disorder since these beliefs will influence when, where and how (and indeed whether) victims of depression will seek help (Jack & Williams, 1991). Education implies understanding current beliefs about depression: which beliefs are adaptive and need to be reinforced, and which beliefs are maladaptive and need to be modified (Antaki, & Brewin, 1982; Frith, & Brewin, 1982). Appropriate diagnosis implies providing helping professionals with information about the culturally shaped beliefs regarding, and manifestations of, depression (Kleinman 1986). Effective treatment implies an understanding of the culturally inculcated explanatory models of depression and the consequent adaptation of therapies so that they address the disorder in a manner sensitive to the nuances of the patient's belief systems (Sue, Fujino, et al. 1991; Wong & Piran, 1995). While there are some similarities in the culture of Chinese people throughout the world, the current research was conducted in China with the particular aim of informing approaches to treating depression in this population both within China and elsewhere. However, this also raises the spectre of a larger issue; who is it that constitutes the 'Chinese people' in China.

Geographically China is the world's third largest nation. Currently its population of roughly 1.3 billion people makes it the most populous country on earth. As of 1995, approximately 70% of the population resided in rural areas, and there continues to be

major in-migration to the cities (State Statistical Bureau of the People's Republic of China, 1996). There are approximately 56 distinct ethnic groups in China. While the vast majority (approximately 91%) of Chinese is considered to be of Han descent, the remaining minorities constitute a very rich and visible cultural mosaic (Chen, 1995; cited in Lee, 1996). In addition, China encompasses a wide variety of geographical and climatic regions. As a result, there is a wide variation in the distribution of natural resources, manufacturing and agricultural production. As with all large nations, this has led to significant regional disparities in terms of social and cultural development, and economic prosperity (Croll, 1997).

In addition, historical antecedents have created widely different regional perspectives on culture and what it is to be Chinese. A long time China watcher and widely recognised expert in mental health in China Veronica Pearson (1999) writes: "Anyone who has heard a Cantonese person fulminating against those 'wheat eaters from the North' for their hoity-toity ways or heard a Beijing cadre expressing distaste for 'those Southerners, only interested in making money, not a line of poetry between them' will already know that the Chinese do not experience themselves as unidimensional; except when differentiating themselves from foreigners" (p. 5). As a result, sweeping statements about the Chinese people and conditions in China are, of necessity, generalisations[1]. In the text that follows, unless otherwise specified, the term Chinese will be used to denote people native to and living in Mainland China. This usage glosses over the rich diversity

[1] In a similar vein, the terms 'Westerner(s)', 'Western' or 'the West' are popular conventions in the literature for referring to those non-Chinese of European or North-American decent. As any, even marginally astute, observer who has travelled more than a few hundred kilometres from his or her place of birth will attest, there is no monolithic West or Westerner. Equating a Frenchman (to his or her face) to an American is more likely to result in impromptu pugilism than agreement. While this usage again glosses over vast philosophical and epistemological differences between cultural and sub-cultural groups subsumed by this label, it does constitute a ubiquitous and somewhat useful heuristic. Therefore, unless specifying a particular national or cultural origin is particularly necessary or germane to the point at hand, I will also subscribe to this usage throughout the current work.

of this population and excludes the vast and diverse diaspora of China, including Taiwan.

Overview of the Current Research

The purpose of this study was fourfold; 1) to determine which causes of depression are viewed as important by Chinese lay people and health care professionals, 2) to determine which source(s) of help to overcome depression is/are most preferred by Chinese lay people, 3) to determine if there is an association between causal beliefs and help seeking preferences for depression and 4) to determine if the level of depressive symptoms and/or experience in the mental health system influences these beliefs and preferences. The major premises of the study were that lay and professional persons' culturally inculcated attributions or 'beliefs' about the causes of depression inform their explanatory models[2] (EMs) (Kleinman, 1977; Kleinman, 1980) of the disorder. EMs influence lay people's help seeking preferences and responses to various interventions, and the approach(s) that professionals use to treat those with depression. In addition to general cultural factors, these beliefs and preferences may be influenced by factors such as age, education, treatment history and, perhaps most importantly, the level of depressive symptoms being experienced by the individual. These factors must be taken into account when trying to understand depression and when trying to design effective interventions to combat the disorder.

---

[2] The 'explanatory model of illness' concept addresses the nature and congruence of both patient and professional beliefs around mental disorder (in this case depression). The dominant implication in the current context is that "the degree to which the clinician shares, or at least, recognizes the client's EM and is able to present interventions in a way that fits the latter 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).

The Concept of Culture

Culture conditions action (Bain, 1996). Culture, particularly conveyed through and embodied in language and convention, in large measure forms personality, epistemology, ontology and philosophy (Bain, 1996). However, for the most part we tacitly accept the notion of culture without necessarily understanding what we mean when we use the term. In order to clarify its intended use and to reinforce the place of culture in the context of the current study, I address the following definitions of this contentious concept.

After reviewing a plethora (over 160) of definitions of culture in the literature of such disciplines as anthropology, sociology and psychology, Kroeber and Kluckhohn (1963) settled on a hybrid definition. They defined culture as "patterns, explicit and implicit, of and for behavior acquired and transmitted by symbols ... culture systems may, on the one hand, be considered as products of action, on the other as conditioning elements of further action" (p. 357). It is in this sense that we are interested in culture's 'conditioning' of perceptions, beliefs and actions related to depression.

The pioneering cultural psychologist Anthony Marsella proffered an expansion on the psychological anthropologist Linton's (1945) definition of culture. Marsella defined culture as "shared learned behavior which is transmitted from one generation to another for purposes of individual and societal growth, adjustment, and adaptation; culture is represented externally as artefacts, roles and institutions, and it is represented internally as values, beliefs, attitudes, epistemology, consciousness, and biological functioning" (1987, p. 9). This latter definition more directly conveys the notion of the macro/micro social/individual 'interactional' character of cultural determinants of behaviour that are so germane to the current discussion.

One of the major suppositions of the current work is that different cultures do indeed condition different worldviews and that these worldviews, in turn, direct behaviour. However, an additional aspect of the foregoing definitions of culture is the conceptualisation of culture as both internal and external. External cultures in the form of institutions that make the laws, shape the economies and determine the distribution of resources are important macro-cultural influences in the overall problem of depression. These external cultural influences determine such things as the economic well being of individuals and groups in society, the institutional reactions to or attitudes toward mental illness and the availability of mental health services. On the other hand, the internal aspect of culture determines how people will respond to depression within the context of any given external culture. While the former will be discussed in this dissertation, the latter constitutes the focus of the current work.

Depression: A Problematic Term

The term depression is somewhat troublesome in that there are both popular and technical meanings associated with it. It carries connotations of an emotion, a symptom, an illness and a disease (Kleinman, & Good, 1985). All of us have experienced low mood that accompanies a disappointment or loss. For the majority of people, these feelings, unpleasant though they are, eventually pass and invoke minimal consequences.

However, the term as it is used in the current context denotes a specific clinical syndrome of more extreme and debilitating proportions. I use the term to refer to the syndrome labelled 'Major Depressive Disorder' in the DSM-IV (American Psychiatric Association, 1994) and the ICD-10 (World Health Organization, 1992) and 'Depressive

Syndrome"[3] (抑 郁 症, yi yu zheng[4], pronounced 'ee you jung') in the CCMD-2-R (Chinese Medical Association, & Nanjing Medical University, 1995). The diagnostic criteria for depression used in these three systems, though not identical, are sufficiently congruent (Zhou, Zhang, & Zhu, 1995, cited in Lee, 1996) to suggest that they describe a cohesive and distinct clinical entity. For this reason I will use the criteria of the DSM-IV in the remainder of the current discussion.

There is an enduring dispute in the cultural literature on depression as to whether or not depression is a valid and invariant diagnostic category across cultures. The arguments range from a *qualified* 'no' (e.g., Marsella, 1978; Obeysekere, 1985) to an *unqualified* 'yes' (e.g., Singer, 1975). The balance in this colloquy seems to tip in favour the former argument (i.e., that depression in some form does exist as a universal diagnostic category but with significant differences in symptoms across cultures). For the present purpose, suffice to say that there is sufficient evidence to warrant the conclusion that depression, in whatever form, exists across cultures; however, cultural factors influence some of its subjective and objective manifestations.

The DSM-IV defines depression as a syndrome that is present "most of the day, nearly every day" for a minimum period of two weeks. The dominant characteristic is depressed mood (in adolescents or children this may manifest as irritability) and/or anhedonia (loss of interest and pleasure in all or most activities). These (if both are present) are accompanied by at least three of the following symptoms: significant weight loss or gain, insomnia or hypersomnia, psychomotor retardation or agitation, extreme

---

[3] The CCDM-2-R does not distinguish between different levels of severity in depression and contains one unitary diagnostic category for the disorder (Chinese Medical Association, & Nanjing Medical University, 1995; Lee, 1996).

[4] Throughout the text that follows I will follow the convention of presenting Chinese terms in Simplified Chinese characters followed by the standard Romanisation (called Pin Yin) used in the People's Republic of China.

fatigue or loss of energy, exaggerated feelings of guilt or worthlessness (which may reach delusional proportions), an inability to concentrate and concomitant indecisiveness and, finally, persistent thoughts of, or attempt(s) at, suicide. To meet diagnostic criteria these symptoms must "cause clinically significant distress or impairment in social, occupational, or other areas of functioning" (American Psychiatric Association, 1994, p. 327). Viewed in this way, it is obvious that depression is not just a transient case of 'the blues'.

While this definition more clearly delineates the subject of the current research in a semantic sense, there is a further feature of depression in China that continues to make it a problematic term; that is, its association with neurasthenia. Although it is still included as a diagnosis in the ICD-10, it is also important to introduce neurasthenia as an illness that is no longer included in other nosologies such as the DSM[5].

The concept of neurasthenia was introduced in the mid-nineteenth century by Beard to describe a syndrome of primarily physiological symptoms that were caused by "exhaustion of the nervous system" (Beard, 1869). Complaints included such things as headache, gastrointestinal problems, low energy, severe fatigue, inability to concentrate, insomnia, loss of appetite and a host of others.

---

[5] Some theorists and researchers believe neurasthenia is experiencing a renaissance in the West in the form of such diagnoses as chronic fatigue syndrome, Epstine-Barr syndrome, myalgic-neuroencephalomyolitis, etc. (Stewart, 1990; Ware, & Kleinman, 1992; Wessely, 1990). In one sense, this would seem to support the argument for neurasthenia as a distinct disorder. However, Wessely (1990), in particular, suggests that the symptoms of the new 'Yuppy flu' as seen in these newer manifestations of neurasthenia are actually disguised manifestations of depression; or as Wessely puts it "old wine in new bottles" (1990, p. 51).

Neurasthenia was considered a disorder of the upper classes and the intelligentsia, and largely due to overwork. As a result, it was almost a mark of honour to suffer from the disorder, since it denoted one's diligence and hard work, for which the best treatment was the 'rest cure' (Lin, 1989). It fell out of favour as a diagnosis in North America because it was considered to be too vague a diagnostic category (Kleinman, 1986).

Neurasthenia was readily adopted in Chinese psychiatry in the 1920's and 30's and flourished particularly under the influence of the Soviet biological model of psychopathology (Lin, 1989). Over the years it has become one of the most widely applied diagnoses in both professional and lay circles in China (Kleinman, 1982). The popularity of this diagnosis is reflected in China by the ubiquitous tonics, medicines, various mechanical and massage devices, and even specially designed 'magnetic' shoes that are purported to alleviate the symptoms of neurasthenia.

As part of the first 'Five year plan' in the 1950's and 60's there was a widespread government-initiated attempt to wipe out the scourge of neurasthenia (Lin, 1989). The cures of choice at that time were Morita therapy (which is currently enjoying a renaissance) and/or group re-education (Lin, 1989). The mass treatment of the time had mixed results. While neurasthenia is becoming a less frequently applied diagnosis among mental health professionals in China (Lee, 1996), if the popular media is any indication, it is still a prominent illness concept among the general population.

Arthur Kleinman, conducted pioneering studies comparing these two disorders in China (Kleinman, 1982; Kleinman, 1986). While he does not deny the possible existence of a discrete disorder of neurasthenia, he maintains that the diagnosis serves primarily as a more socially acceptable mantle for the less desirable diagnosis of depression in both popular and professional circles in China (Kleinman, 1986). He also conceptualised

neurasthenia as a form of social discourse through which those in a low-power position could assert control and achieve needed changes in work or living conditions (e.g., time off, job reassignment, or transfer to a work unit closer to family).

Kleinman (1982) found that of the 100 diagnosed neurasthenics he studied at Hunan Medical College, 87 met DSM-III criteria for Major Depressive Disorder. Yan (1989) argues that neurasthenia merits its own place in the nosologies as a diagnosis distinct from depression. The assertion here is that if depression is found in populations of people suffering from neurasthenia, the two are likely co-morbid, with depression possibly being one of the sequelae of neurasthenia. The debate is heated when it comes to the question of the validity of neurasthenia as a distinct disorder (see for example: Kleinman, 1986; Kleinman, 1988; Lin, 1989; Liu, 1989; Yan, 1989). The principal controversy revolves around the symptom presentation of neurasthenia (being primarily somatic) versus that seen in depression (being primarily psychological) and the differential rates of diagnosis. In light of this controversy, therefore, it is only prudent to include considerations of neurasthenia in any research on depression in China.

Interface of Culture

Our cultural beliefs influence virtually all that we do. They influence our decisions regarding everything from the clothes we wear and the food we eat, to how we conduct interpersonal relations and how we view others, the world and ourselves.

Our cultural knowledge about depression derives from many sources and exerts its influence at several levels. Furnham and Kuyken (1991) state, "the knowledge people have is largely derived from a corpus of common sense about depression and anti-depressive behaviours that are derived from interpersonal communication between lay people, academic professionals, and depressed people, and social institutions such as

schools and the media etc." (p. 338). Marsella said that "since cultures condition different concepts of self, and since self is inextricably linked to the definition, experience and expression of mental disorder, it is clear that cultural factors are closely related to mental disorders." (1982, p. 362). He maintains that cultural influences shape both subjective and objective manifestations of depression. The implication is that culture's influence operates at different levels. At one level, we have the influence of specific, culturally transmitted knowledge of depression. At another level is the influence of culturally transmitted beliefs about self-structure, existence, and general health and illness beliefs. It is not surprising then to realise that culturally shaped beliefs (derived from multiple sources) define our understandings of and reactions to mental disorders generally and perhaps have their greatest impact on depression.

Cultural belief systems inform our EMs of disease and direct our coping efforts in accordance with the particular explanatory model to which we subscribe. Angel & Thoits (1987) defined a model of cultural influences on the process of how people recognise and deal with illness. This involves the processes of symptom recognition, labelling and help seeking. Their model delineates a process involving cultural influences on the perception of the physiological and/or psychological aspects of disorder, categorisation of the symptom as normal or abnormal and, finally, its expression in help seeking behaviour. Culturally defined illness and medical beliefs, and social comparison play vital mediating roles in determining outcomes at each juncture.

Angel & Thoits (1987) posit that culturally shaped medical epistemologies dictate notions about what constitutes health and illness, symptom and non-symptom. A physical or psychological anomaly is recognised as a symptom of illness only if it fits within the parameters defined as abnormal in the context of the particular system of medical beliefs. Internally, factors such as confluence, chronicity and degree also have a

bearing on symptom recognition. An isolated, brief or mild anomaly is less likely to be categorised as a symptom of disorder than one that is accompanied by other anomalies, is persistent and severe. Externally, social comparison plays a role in symptom recognition. If others in one's reference group frequently experience similar anomalies, they are less likely to be categorised as symptoms of disorder.

This model suggests that symptom recognition is very much a function of culture. If the individual, or those around him or her, do not recognise the physiological, psychological and/or behavioural anomalies as symptoms, there will be no perceived need for help. If the anomalies are perceived as symptoms of disorder, the individual's system of health beliefs will dictate where s/he will first turn for the necessary help.

In China the family most often decides, based, in part, on culturally inculcated beliefs, what to do when mental disorder is encountered. "Family members ... make all the health care decisions for the patient. They decide which type of care provider will be sought (Western doctor, Chinese traditional doctor, or folk healer) and, if hospitalisation is necessary, it is they, not doctors, who make the final decision about when the patient is admitted and discharged" (Pearson, & Phillips, 1994). If a decision is made to seek help for depression, culture also influences the efficacy of interventions offered.

The mediating influence of depression

Styrone (1990) described in exquisite detail the impact of depression on his daily functioning and the concomitant alterations in his perceptions of himself and the world around him. Cognitive theory of depression (Beck, Rush, Shaw, & Emery, 1979) and descriptions such as Styrone's suggest that the level of depressive symptoms that an individual is experiencing also exerts a significant influence on his or her worldview.

The implication for the current research is that lay people's reports regarding their beliefs about the causes of depression and their preferences for seeking help to overcome depression may be influenced by their level of depressive symptoms. Therefore, it is important to compare the reported beliefs and preferences of depressed and non-depressed people to determine if such an influence exists and, if it exists, to understand the nature and direction of this interaction.

The influence of the severity, or the absolute presence or absence of symptoms, is also important in determining how others may respond to the depressed individual. In other words, those not experiencing depressive symptoms may have a different view of the problem than the depressed individual. Non-depressed family or friends will offer advice about overcoming the disorder that is consistent with their perspective, which may or may not be congruent with that held by the principal sufferer. This will impact the help seeking options explored by the principal sufferer.

Also in this context, a conceptual insight can be drawn from attribution theory. Attribution theory (Weiner, 1985) suggests that the aetiological perspective of disorder that is held by friends, family members and others in society, influences how they view the principal sufferer. Similarly, the aetiological perspective of disorder held by the principal sufferer could also influence his or her self-perceptions. If the cause of the individual's depression is perceived as being within his or her control, both the principal sufferer and/or those around him or her will be more likely to assign blame or responsibility for the disorder to the sufferer. In this case the sufferer may be expected to 'get over it' on his or her own. On the other hand, if the cause is seen as something beyond the individual's control (e.g., due to biological factors), then family, friends and others in the sufferer's social network may be more sympathetic and the individual may

experience less self-recrimination (Kuyken, Brewin, Power and Furnham, 1990). In this case, the individual is more likely to pursue (or be referred to) outside sources of help.

Some practical implications of culture's influence on depression

A significant and growing body of research suggests that members of the Chinese community (and other groups) in Canada and elsewhere under-utilise effective psychological and psychiatric services. This under-utilisation exists for a wide range of mental disorders (Brown, Stein, Huang, & Harris, 1973; Lin, Tardiff, Donetz, & Goresky, 1978; Snowden, & Cheung, 1990; Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Sue, & McKinney, 1975; Sue, & Sue, 1974). While there seems to be an improvement in utilisation in various centres (e.g., Seattle) as a function of the implementation of various "cultural sensitivity" initiatives within the past decade or so, the numbers overall are still not encouraging (Fujino, Hu, Takeuchi, & Zane, 1991).

The under-utilisation problem has been explained in terms of Chinese conceptions of and attitudes toward mental disorder (Marsella, Kinzie, & Gordon, 1974; Kleinman, 1986). In Canada and other Western settings Chinese beliefs may be incongruent with those held by members of the dominant culture (including those providing psychological and psychiatric services). These conceptions militate against depressed Chinese seeking psychological or psychiatric help (often until symptoms are so severe that treatment is more difficult and uncertain, and the disorder may have become chronic) and against the efficacy of the interventions offered. If interventions can be offered that are congruent with or complement the Chinese patient's belief system, it may be possible to increase participation in, and compliance with therapy (psychosocial, pharmacological or others) among members of this population. Further, an

understanding of the fundamental beliefs around depression can help to inform education strategies targeted at the Chinese community.

Importance of the Current Research

The problems caused by depression are by no means specific to the Chinese context or to developing nations particularly. While the impact of depression is apparent in every corner of the globe, the discussion that follows will focus on the impact of depression in China. However, some of the insights gained from this research ideally will be applicable to other populations as well.

Economics of Depression

Recently the World Health Organization's Ad Hoc Committee on Health Research Relating to Future Intervention Options (1996) released statistics on causes of disease burden in developing countries. Disease burden in this context represents the cost of various distinct diseases to the total economy of a country or group of countries. The committee estimated that in 1990 Unipolar Major Depression constituted the fourth greatest health care economic burden in the developing countries of the world. Extrapolating current trends, the committee estimated that by the year 2020 depression would rank as the number one cause of disease burden in developing countries, ahead of others such as heart disease, tuberculosis or HIV.

The figures for the People's Republic of China are similarly alarming. The committee estimated that in 1990 depression was the number two cause of disease burden in China (representing 6.2% of the total disease burden - behind chronic obstructive pulmonary disease). It is expected that depression will move to the number 'three' position (representing 7.3% of disease burden - behind chronic obstructive pulmonary disease

and cerebral vascular disease) by the year 2020 (Ad Hoc Committee on Health Research Relating to Future Intervention Options, 1996)[6].

At this writing, figures detailing the cost of depression to the Chinese economy were not available. Similarly, a comprehensive examination of the cost of depression to the Canadian economy has never been carried out. As a result, we rely on figures from the United States, which are assumed to reflect similar, though proportionately lower, costs here. For the year 1989, the estimated cost (including costs for medical care, absenteeism, and related costs) of depression to the American economy was estimated to be approximately 27 billion US dollars (New Federal Guidelines, 1993, cited in Depression: An overview of the Literature, 1995). This estimate covers only costs incurred through 'diagnosed' cases and does not take into account those cases of depression that went undiagnosed, were treated outside the medical system or were misdiagnosed and the patients treated for other problems. A study of the economic burden of depression in Britain and Wales (Kind, & Sorenson, 1993) estimated indirect losses to these economies from depression at approximately 3 billion British pounds. It is likely that the dollar cost to the Chinese economy is proportionately high.

Such an economic burden is staggering given the many other social and economic challenges that the Chinese face in the move to a market economy. It is, therefore, important that effective measures are found to deal with the problem of depression in China if only to reduce the economic burden to that economy. This problem is also of critical importance to the Canadian health care system since an increasing proportion of Canada's immigrant population is originating from the countries of Southeast Asia

---

[6] I gratefully acknowledge the work of Dr. Michael Phillips for extracting and interpreting these figures for China from the statistical data in the cited report.

(Statistics Canada, 1997). To facilitate the most effective modes of intervention it is crucial that we have a clear understanding of this disorder and how people respond to it. However, the ultimate aim is not only to reduce the costs of depression in terms of the national economic burden, but also in terms of the cost to individual families who are being called upon to bear an increasing proportion of the burden of health care costs in China and elsewhere.

By reaching depressed people earlier in the help seeking process with more effective interventions, we can accomplish several things:

- First, it may be possible to reduce the estimated 20% to 30% of primary care visits that may be accounted for by depression and, thus, reduce the burden on the health care system (Barrett, Barrett, Oxman, & Gerber, 1988; Kamerow, 1988; Schulberg, & Burns, 1988).

- Second, it may be possible to reduce the amount of productivity lost to this disorder by reaching depressed individuals with more well targeted and effective treatments.

- Finally, if depressed individuals can be reached earlier, and with more effective interventions, we can minimise the suffering and financial burden to individuals and families that results from inaccurate diagnoses and inappropriate treatments.

The Problem of Suicide

Recent literature has indicated that suicide is an ever-increasing problem in China (Li, & Baker, 1991, cited in Pearson, 1995; Murray, & Lopez, 1996). In fact, it is estimated that China's suicide rate is among the highest in the world (Phillips, Liu, & Zhang, 1999). The figures suggest that suicide is the number one cause of injury death in China, ahead

of such things as MVAs and drowning (Pearson, 1995). Even more alarming is the fact that roughly four times as many suicides occur in the rural areas than in urban centres. However, the most astonishing assertion is that, unlike the situation that obtains in the rest of the world, in China women are more likely than men to die from suicide (Phillips, Liu, & Zhang, 1999). While these authors implicate factors such as economic deprivation and rapid social change in the alarming rate of suicide in China, depression as a discrete entity must account for a large proportion of these deaths. Therefore, it is of paramount importance that the problem of depression be addressed with the most effective means available with the hope that we can diminish, even slightly, the numbers of individuals ending their lives in China.

Causal Beliefs and Help Seeking

Causal beliefs play an essential role in determining the actions depressed people will take when confronted with the disorder. If members of a culture or sub-culture hold biological causal beliefs about depression then they are more likely to seek and expect biological interventions when depressed. If psychosocial causes are believed to be primary, psychosocial interventions will be sought (Whittle, 1996). Concomitantly, if members of a particular culture or subculture hold that depression is caused by biological factors, compliance with psychosocial interventions is likely to be low (Foulks, Persons, & Merkel, 1986). Therefore, an understanding of depressed people's beliefs about the nature and causes of depression is an important key, not only to understanding help seeking preferences and providing effective therapies, but also to increasing patient compliance once intervention has been sought.

Biological/Psychological Aspects of Depression

Horatio Fabrega (1974), a leading figure in social psychiatric research, reinforced the notion of culture's influence on depressive symptoms. He emphasised the dichotomous nature of mental illness in his paper on culture and depression. Fabrega proposed that mental disorder must be understood on both micro (biological) and macro (behavioural) levels:

> *One assumes ... that man considered biologically (i.e., chemically, neurophysiologically, anatomically, etc.) is the same everywhere, and that alterations in his biology are likewise similar, i.e., involve identical mechanisms and processes. However, how these biological changes become transformed into various specific behaviors and why they assume the particular expression that they do in distinctive cultures is dependent on fundamental symbolic categories that structure and encode behavior. (p. 384).*

In other words, cultures condition different beliefs about the nature and causes of health and illness. While the biological changes that arise in depression may be relatively consistent throughout the human species, people in one culture may experience the biological changes of depression in fundamentally different ways than those in other cultures. The result of this is that their help seeking behaviour and the symptoms they present when seeking help for depression are also likely to be different.

Depression as Disease versus Illness

The anthropological psychiatrist Arthur Kleinman (1977), a leading figure in the study of depression in China, asserted that depression should be conceptualised as both a

disease and an illness. The disease 'depression' is constituted of the physiological changes or 'alterations in biology' mentioned by Fabrega above. Considered in this way depression is relatively invariant across cultures. The illness aspect of depression is the subjective, interpersonal and cultural reactions to disease (in this case, depression). The illness aspects of depression are subject to cultural influence and constitute a major component of the subject matter of this dissertation.

Diagnostic and Treatment Issues

One result of the beliefs or EMs shaping the illness component of depression is that some depressed Chinese may present somatic symptoms of depression over the psychological or existential concerns. Some of the reasons that have been advanced for this are social acceptability of biological symptoms over psychological symptoms (Kleinman, 1986), the treatment setting in which symptoms are elicited (Cheung, & Lau, 1982), fundamental illness beliefs shaped by cultural models of self and illness (Marsella, 1980), etc. What often occurs is that the depressed Chinese patient, emphasising physical symptoms, repeatedly seeks medical consultations and treatment.

Many individuals with 'primary' depression who present with somatic symptoms end up receiving some form of biomedical intervention. Intrusive and unnecessary diagnostic tests, procedures and medications can lead to iatrogenic problems that further complicate proper treatment and result in unnecessary suffering and costs to the patient, and overburden the health care system. The earlier effective interventions can be brought to bear on depression, the lower the potential for economic loss and human suffering caused by misdiagnosis and inappropriate treatment.

Beliefs and Treatment

Patients' beliefs also exert a strong influence on the efficacy of professional attempts to deal with depression once outside help has been sought (Kleinman, 1980). In his analysis of the interaction between culture and psychotherapy, Havenaar (1990) suggested that as much as 60% of therapeutic efficacy might be accounted for by the degree of congruence between the belief systems held by therapist and patient. He maintains, "culture is one of the most important factors active in therapy. It certainly exceeds the importance of any single 'specific' factor related to different schools and theories and perhaps even that of the psychotherapeutic alliance" (Havenaar, 1990, p. 9). Havenarr's propositions have been challenged on several fronts. Several authors (e.g., Pedersen, & Ivey, 1993) have suggested that all of psychotherapy can be considered to be culturally dependent, while others suggest varying degrees of influence by factors such as the particular school, characteristics of the therapist and the client etc. (e.g., Lambert, 1992). In any case, it is clear that cultural factors play a role in the efficacy of psychotherapy.

Frank (1961, cited in Havenaar, 1990, p.9) posited four essential and defining characteristics of effective therapy. Attitudes and beliefs about each of these elements of therapy are inculcated within the patient's culture. The characteristics include:

(1) a special relationship (intense confiding)

(2) a therapeutic setting or context (socially sanctioned/recognised)

(3) a rationale (myth) to explain client's suffering

(4) a procedure (ritual) to counteract the suffering (that is based on the rationale)

In this context, the 'special relationship' exists between the patient and an 'other', which could consist of an icon (e.g., Lourdes), a psychiatrist, or a shaman. The therapeutic setting could be a temple, a hospital, or a yurt on the steppes of Inner Mongolia. The rationale could be anything from a neurochemical imbalance, childhood trauma and inner conflict, to an improper diet or spirit possession. The ritual could run the gamut from psychoanalytic, cognitive or drug therapy, to herbal soups or an exorcism. Whether it is a pharmacological, or psychosocial intervention that is sought (the latter including the work of 'faith healers'), the congruence (real or perceived) between the helper's and the patient's beliefs will determine compliance with, and thus, the effectiveness of the therapy offered. If the healer has a clear understanding of the patient's beliefs about depression, he or she will be in a better position to provide treatment in a way that is complementary to the patient's belief system and thereby enhance rapport and therapeutic efficacy.

While this is not to imply that psychotherapy is the only or even the most effective approach to treating depressed Chinese patients, there are indications that psychotherapy has been an effective intervention

In sum, at this time, and for the foreseeable future, depression poses a significant problem for the Chinese people in terms of economic cost and human suffering. Culturally shaped beliefs influence both the objective and subjective manifestations of the disorder and consequently the types of help people will seek. These beliefs largely determine the effectiveness of the various interventions aimed at helping people to overcome depression.

Definition of Terms

In the context of this study the following definitions of terms are used:

- *Clinical status:* defines the individual with respect to whether or not s/he is being currently treated as an inpatient or outpatient in a clinical setting.
- *Depression*: an active condition defined by the diagnostic criteria for 'Major Depressive Disorder' by the DSM-IV and the ICD-10, or 'Depression' by the CCDM-2-R. This definition includes both 'first episode' and 'recurrent' subtypes.
- *Lay people*: are individuals who have not had formal training in any of the major mental health related disciplines (e.g., medicine, psychology, psychiatry, nursing, social work, etc.).
- *Non-clinical subjects*: are individuals who are not currently in active treatment in a clinical setting for any mental disorder.
- *Professional subjects*: are individuals who deal with depressed people as part of their professional function and may include: acupuncturists, herbalists, massage therapists, psychiatrists, psychologists, Traditional Chinese Medical (TCM) doctors, Western medical doctors (general practitioners), etc.

Research Questions

1. Which attributions do Chinese lay people and professionals rate as important causes of depression?

2. Which help seeking alternatives for depression are rated most highly by Chinese lay people?

3. Is there a relationship between Chinese lay people's ratings of causal attributions and those of help seeking preferences for depression?

4. Is there a relationship between subjects' scores on the Chinese Depression Inventory and their ratings of Causal Factors for depression and/or their ratings of Help-seeking Factors?

5. Does clinical status affect subjects' ratings of Causal Factors for depression and/or their ratings of Help-seeking Factors?

Delimitations of the Study

While many subject variables were measured using the questionnaires administered in the current study, only analyses related to the above research questions are reported in the current work. Some analyses (e.g., analysis based on demographic variables, analysis of the CDI items, etc.) will be reported in separate publications.

This research employed a very narrow definition of depression. This was done in an effort to keep the disorder under study as homogeneous as possible. It was believed that

the underlying mechanisms (biological and/or psychological) and manifestations of other forms of depression (e.g., mania) would influence perceptions of the disorder and, concomitantly, beliefs and help seeking preferences. Therefore, no attempt was made to sample the full range of depressive illness (e.g., Bipolar Disorder, Cyclothymic Disorder, Dysthymic Disorder, etc.).

Since previous experience in a clinical setting was considered likely to shape the beliefs and help seeking preferences of clinical subjects, the inclusion criteria had been designed to limit these participants to those undergoing treatment for a first episode of the disorder. Unfortunately, due to the limited numbers of clinical subjects, it was not possible to limit this sample to people suffering from a first-episode of the disorder. Thus, it was not possible to differentiate between subjects who may have had a longer treatment career in mental health settings from those hospitalised for the first time.

In the same context, the selection of the non-clinical sample had been designed to exclude individuals who had been previously treated for a psychological problem. However, it was believed (based on the literature, and both my personal and professional experience in China) that during the face-to-face screening, non-clinical subjects would have been reluctant to reveal previous treatment for a psychological or psychiatric problem. Therefore, a section was included at the end of the help seeking alternatives questionnaire that requested information regarding whether or not the subject had experienced a similar problem (to that presented in the vignette), whether they had sought help from others for the problem and from whom they had sought help.

The current research was intended as an exploratory study of causal beliefs and help seeking preferences among Chinese people. The major emphasis was not on cross-

cultural comparisons of the findings. Although comparisons were inevitably implied and some were referred to in the literature review and discussion, the purpose of the current research was to examine the causal beliefs and help seeking preferences of Chinese people in the People's Republic of China. Again, more detailed and specific cross-cultural comparisons will be explored in future publications.

The selection of 'professionals' to include in the study was also not exhaustive. For example, it is likely that a barber, bartender or bus driver, or for that matter, a family member or a friend, may dispense forms of informal therapy to depressed individuals. While their contribution to the management of depression should not be trivialised, it was not feasible to include all such 'non-formal' resources given the scope of the current study. Similarly, while shamans treat many people with mental health problems in China (particularly in the countryside), two attempts to locate shamanistic healers were unsuccessful. Such individuals are reluctant to reveal themselves to people from outside their community due to legal sanctions against the practice. Therefore, the discussion of shamanism is limited to information available anecdotally from other sources (e.g., TCM doctors, psychiatrists, etc.) and that available in the literature.

Personal Statement

The research disseminated in the pages that follow is the fruit of my ten years of formal and informal investigations of the problem of depression in China. What began as an interest in the relatively low rates of suicide and depression (then reported) for the Mainland Chinese people, led to my many sojourns in that country. These were undertaken for the purpose of shedding more light on the influence of Chinese culture on mental disorders in general and on depression specifically. I consider this dissertation to be only an 'interim report' on an odyssey of discovery in this very important aspect

of the human condition among one fifth of the world's population. If I could foreordain the outcome of this current effort, it would be that we arrive at a better understanding of depression that would allow us, even in a small way, to mitigate its impact on the lives of the Chinese people in particular and of depressed people in general.

Chapter 2 - Review of the literature

Overview

The literature reviewed in this section is specific to the main objects of the dissertation[7]. The review is divided along three broad lines of research: 1) research about causal beliefs; 2) research about help seeking; and 3) research about causal beliefs and help seeking preferences or behaviours combined. The distinction is somewhat arbitrary since much of the research on causal beliefs alone also suggests implications for help seeking and vice versa. However, the studies included in the latter section addressed specifically, and in some way attempted to measure the relationship between, beliefs and help seeking.

A cautionary note is warranted here. While it may seem valid, at a very general level, to compare 'non-Asian' beliefs with those of 'Asians', some studies (e.g., Tracey, Leong, & Glidden, 1986, reviewed below) have shown significant differences in problem perceptions between the various groups that have often been subsumed within the category of 'Asians'. As has become evident in the cross cultural literature in psychology and other disciplines, there are significant differences in the cultural experience and therefore the underlying health beliefs of such groups as Japanese, Filipino, Korean, Thai and Chinese (not to mention the ubiquitous 'White' or 'Caucasian' group) from different regions within and outside their respective countries or ancestral homelands[8]. Therefore, the use of labels such as 'Asians' and 'non-Asians'

---

[7] Several of the studies reviewed below were also the subject of review for my Master's thesis, while several that were reviewed for that work are not included in the current review due to limited relevance. (Sinclair, 1994)

[8] For an excellent overview of this problem and description of some factors that differentiate the various sub-groups subsumed under the label of 'Asian-Americans' the see the chapters by Lee (1998) and Tanaka, Ebreo, Linn, & Morera (1998).

frequently applied in the cross-cultural literature, may serve more to obfuscate than to inform about observed differences in research that utilises this type of categorisation.

Causal Belief Research

The studies described in this section fall into two broad categories. First, I reviewed studies of lay beliefs about causes of and/or cures for disorders other than depression and those pertaining to mental disorders generally. Finally, I reviewed studies that focus on causal beliefs about depression specifically. There is some disagreement about the interdependence of causal and cure beliefs. Some authors (e.g., Furnham & Henley, 1988) suggest that knowledge of lay peoples' beliefs about cures reflect their theories about the causes of mental disorders. The other school of thought is that these two dimensions, while related, require separate investigation (e.g., Luk, & Bond, 1992). Rather than exclude studies of beliefs about cures, I made the tacit assumption that their relationship to causal beliefs was strong enough to warrant their inclusion.

Causal Beliefs About Mental Disorder in Non-Chinese or Mixed Populations

In one of the pioneering studies of causal beliefs, Nunnally (1961) examined the extent of American lay and professional people's knowledge about the causes and cures of mental disorders and about people suffering from mental disorders. He found, as expected, that professionals held views that were congruent with popular psychiatric and psychological theories of that period. To greater or lesser degrees, Nunnally's lay sample endorsed the following as causes of, and curative factors for mental illness. Lack of willpower causes mental disorders and increased willpower ameliorates them. Women are more prone to mental disorder than men. Mental health is maintained by focusing on pleasant thoughts. Mental illness can be ameliorated by the positive

influence of well-adjusted people in one's environment. Pressures in the immediate environment, rather than internal personality dynamics, cause mental illnesses, and improvements in the environment can alleviate them. Susceptibility to mental disorder increases with age. Dietary factors, physical damage and diseases of the nervous system cause mental disorders, and that biological interventions can ameliorate them.

Nunnaly found that lay people had relatively extensive and sophisticated theories about mental disorders. His lay subjects made a clear association between analogous causes and cures for mental disorders. Psychosocially caused disorders were associated with psychosocial interventions. Biologically caused disorders were associated with bio-medical interventions. Nunnaly's work spawned many subsequent studies, some of which are reviewed below.

Using Nunnaly's questionnaire in one of the first cross-cultural studies of beliefs about mental disorders, Arkoff, Thaver and Elkind (1966) compared the beliefs of psychologists and American students with those of Asian (Chinese, Filipino, Japanese and Thai) students about mental disorder. Relative to the former two groups, Asian students believed that willpower and the avoidance of unpleasant thoughts played a much greater role in enhancing mental health. Further, Asian students assigned more significance to the efficacy of guidance and support as a curative factor than did either of the comparison groups. Asian students, more than American students or psychologists believed that counselling was a "directive, paternalistic and authoritarian process" (Arkoff, Thaver, & Elkind, 1966, p. 219). This study was the first in North America to contrast the beliefs of Asians with those of non-Asians. It initiated further research into the notion that culture inculcates very different understandings of mental disorder and the therapeutic process.

Ten years later, Sue and his colleagues (Sue, Wagner, Ja, Margullis and Lew, 1976) also used Nunnaly's 40-item questionnaire to compare the beliefs of Caucasian and Asian-American students about mental disorder. Asian students endorsed the beliefs that willpower is the basis of personal adjustment, that women are more prone to mental disorder than men, that the avoidance of morbid thoughts enhances mental health and that mental illness is brought on by organic factors. Controlling for demographic and educational variables, however, only two significant differences emerged. Asian students, more than their Caucasian counterparts, believed that avoidance of morbid thoughts militated against mental illness and that mental illnesses were the result of organic factors.

Sue et al (1976) asserted that the belief in willpower as the basis of mental health, and the belief that 'avoiding morbid thoughts enhances mental health' was consistent with the notion that Asian cultures generally emphasise self-control. They also suggest that the attribution of organic causes for mental illness is consistent with the, often cited, tendency for Asians to somatise psychological distress. The principal contribution of this research was to link Asian cultural constructs, in a more systematic way, to their influence on perceptions of mental disorder and therapeutic interventions.

Knapp and Delprato (1980) took the question of willpower a step further in their examination of lay beliefs about psychological problems. They had subjects rate the degree to which willpower was important in overcoming 24 behavioural problems. Their analysis revealed that willpower was perceived to be differentially important to overcoming four classes of problems (in order from most important to least important): 'self-indulgence' problems (e.g., smoking), 'non-self-indulgence' problems (e.g., shyness), 'psychopathological' problems (e.g., nervous breakdown), and 'ability deficits' (e.g., poor mathematical ability). The authors speculated that the efficacy of behavioural

therapy might be attenuated for those problems in which willpower is perceived a necessary curative factor. Another interesting finding was the fact that they found no influence of education on subject's ratings of the importance of willpower in overcoming any of the problems.

Extending Knapp and Delprato's study, Knapp and Karabenick (1985) examined the importance of 20 contributors to overcoming six psychological problems. For this study, the authors selected problems from two categories studied by Knapp and Delprato (1980): smoking, overeating (self indulgence problems), nightmares, hearing voices, stuttering and fear of dogs (psychopathological problems). They extracted four factors from the 20 cure attributions: social consequences, inner control, understanding and positive outlook or instrumental approach. With respect to inner control, the study supported the findings of Knapp and Delprato (1980). Subjects rated this factor as most important for overcoming self-indulgence problems such as smoking and overeating. The attributions that made up the 'understanding and positive outlook' (instrumental approach) factor were rated as more important than inner control for overcoming problems that imply some underlying psychopathological condition (nightmares, hearing voices, stuttering and fear of dogs). The 'social consequences' factor was perceived to be the least important in overcoming all of the problems studied.

Several attempts have been made to analyse causal beliefs according to theoretical constructs. In one such attempt, Norcross, Prochaska and Hambrecht (1985) developed the Levels of Attribution and Change scale (LAC) to measure people's perceptions of the causes of mental disorder. The theoretical basis for constructing the scale was the Transtheoretical Model of Psychotherapy (TMP) (Prochaska 1984; Prochaska, & DiClemente, 1984).

Briefly, TMP represents an attempt at constructing a sort of 'grand unification theory' of psychotherapy. This model targets particular therapeutic approaches according to a hierarchical structure dictated by beliefs about the nature and the causes of disorder (i.e., a particular therapeutic approach is used to achieve change with problems perceived to be originating at a particular 'level' in the hierarchy). Norcross et al (1985) proposed that individuals attribute causes of mental disorder at different levels on a continuum. At one end of the continuum are external or distal causes, on the other end are internal or proximal causes. For example, behavioural approaches may be targeted at disorders that are perceived as being caused by learning contingencies in the external environment (distal level causes) and psychodynamic approaches may be used to address problems perceived as being caused by more deeply ingrained issues from early childhood (proximal level causes). In a given case, these 'levels' of causes are defined by the beliefs or perceptions of the clinician and/or of the patient about the presenting problem. By understanding an individual patient's model of causality, the clinician may be better able to adapt therapy to suit the patient's particular needs, or to use this information as a point of reference from which to advise the patient about the causes of disorder to facilitate a particular therapeutic approach.

Norcross et al (1985) administered the LAC scale to a sample of college students and asked them to rate the importance of 60 attributions as causes of a single problem of the subject's choosing. Principal components analysis revealed that their 60 attributions coalesced into ten scales. The scales were labelled: spiritual determinism, bad luck, biological inadequacies, environmental difficulties, maladaptive cognitions, familial conflicts, interpersonal conflicts, intrapersonal conflicts, chosen lifestyle and insufficient effort. A second order analysis determined that these ten scales coalesced into two broad dimensions labelled: Internal-Dispositional causes and External-Situational causes.

Norcross et al suggest that the LAC scale can be useful to facilitate therapy by providing an understanding of a particular patient's model of causality. However, it is also conceivable that the model may be helpful in making more macro-level adjustments to therapies. In other words, by understanding models of causality held by average members of a particular cultural or sub-cultural group, Norcross et al's model may help to inform attempts at making general cross-cultural adjustments to existing therapies for application with members of the particular group. In discussing the application of the LAC the authors assert that:

> *Quite frequently and unfortunately, psychotherapists do not assess or even understand their client's attributions about the presenting problem. Even if the client's attributions are understood, the therapist may not share the client's perspective. Discrepancies in causal attributions may subsequently be labelled as resistance or, poor insight or irrational beliefs. In most cases this may indeed be true; however, in some cases, differences in opinion may be simply that, and not indicative of psychopathology. (p. 646).*

This analysis reinforces the notion that an understanding of lay people's causal beliefs is crucial to both accurate diagnosis and to effective therapy.

Hambrecht and Hohmann (1993) used the LAC to examine German psychiatric patient's attributions about the cause of disorder and compared these with a sample of German students. They found that responses from the student sample coalesced into 6 factors while those of the psychiatric patients coalesced into 3 factors. They surmised that, the fact that psychiatric patients do not make as fine discriminations about the

causes of disorder as non-patients might be, in part, a function of the therapeutic setting. This is because patients may be informed intentionally or unintentionally about a particular theoretical perspective regarding the cause of their disorder in the process of therapy. Thus, patients may acquire a less diffuse, more coherent or focussed representation of disorder than non-patients as a function of the therapeutic approach they experienced in therapy and/or the setting in which they were treated.

Also of interest was the finding by Hambrecht and Hohmann (1993) that neurotic and personality disordered patients, more than those diagnosed with affective psychosis, endorsed intrapersonal causes for their disorders. Thus, we can see from this research that psychiatric patients partial out the causes of their disorder along less discrete dimensions than do non-patients and that diagnosis can also influence the endorsement of various attributions by these patients.

Furnham and Rees (1988), another team of researchers influenced by the work of Nunnaly, continued the factor analytic approach in their study of lay theories about the causes of schizophrenia. Perceived causes coalesced into five factors: stress and pressure, biological, genetic, backwardness (cognitive deficit), and brain damage. From these results Furnham and Rees concluded that lay causal explanations strongly resembled formal theories of causality for schizophrenia. They stated that "subjects seemed to prefer environmental explanations referring to social stresses and family conflicts. This would indicate that in Britain, a psychosocial model of mental illness is adhered to, rather than a medical model" (Furnham & Rees, 1988, p. 218).

In a series of semi-replicative studies, Adrian Furnham collaborated with Susan Henley to examine lay attributions of cure for a variety of disorders. These studies included lay perceptions about the cures for agoraphobia, anorexia nervosa, compulsive gambling,

and schizophrenia (Furnham, & Henley, 1988), alcoholism, depression, sexual problems and shyness (Henley, & Furnham, 1988), and hypertension, peptic ulcers, asthma, dermatitis and migraine (Furnham, 1989). The factor structures found in these studies were very similar and included such curative influences as inner control, receiving help, understanding, social consequences, avoidance, physical basis and fate. Understandably, subjects in these studies assigned different importance to each factor as to its perceived curative efficacy in relation to different disorders.

The general conclusion to be drawn is that, for the British samples, the 24 curative items tended to coalesce into almost identical factor structures despite the fact that they related to different types of problems. This suggests that, with respect to cures (and, as the authors suggest, perhaps causes as well) British lay people perceive consistent underlying curative dimensions for overcoming psychological or psychologically related disorders. Most germane to the current research is the finding that Britons endorsed receiving help, understanding (of the disorder), and inner control as most important to overcoming depression, and fate as the least important curative factor. If the relationship between cures and causes is as direct as suggested by these authors, this would imply that their subjects perceived psychosocial factors, informational factors and lack of inner control as principal causal agents in depression and that fate plays little role in causing the disorder.

Foulks, Persons and Merkel (1986) examined the structure of, and the relationship between American psychiatric outpatients' causal beliefs of mental disorder and their compliance with therapy. Using the Cause of Illness Inventory, which they created for this study, they found that the patients in their study held significantly more causal beliefs that were congruent with current 'medical' (bio-psycho-social) theories of mental disorder than 'non-medical' (superstitious, alternative) beliefs. Medical beliefs included

such things as emotional upset, psychological problems, tension in the family and childhood problems. Non-medical beliefs included such things as fate, God's will, sins, unclean surroundings and dampness.

Foulks, Persons and Merkel's (1986) research revealed that individuals subscribing to more 'medical' beliefs attended more therapy sessions and were less likely to terminate therapy prematurely and/or without consulting their therapist than were those who subscribed to more 'non-medical' causal beliefs. They said it was interesting that although all of their subjects endorsed at least some 'medical' causes, nearly one third also endorsed non-medical causes as well. This would seem to indicate that while the majority of their subjects held causal theories of mental disorder similar to current bio-psycho-social notions, a significant proportion concurrently held superstitious and/or alternative causal beliefs.

One difficulty with the Foulks, Persons and Merkel (1986) study is that the researchers combined subjects with many different disorders into one group. It is likely that subjects suffering from schizophrenia hold different beliefs about the cause of their disorder than subjects suffering from affective disorders. While their sample size did not allow for such fine discriminations it would be useful to examine whether diagnosis would distinguish between individuals holding different constellations of causal beliefs.

Serota (1987) examined transcripts of interviews with first-episode psychotic patients in Hawaii about the nature and causes of their disorder. She found significant differences based on ethnicity and diagnosis. In terms of ethnicity, Serota found that Hawaiians and Filipinos, more than Caucasians or Japanese, reported that their disorders were of a spiritual or magical nature. Patients with affective psychoses interpreted the nature of their disorders as psychological and that they were caused by psychosocial life stresses.

In contrast, those suffering from schizophrenic or schizophreniform disorders did not recognise their illnesses as mental disorders and offered bizarre and psychotic ideational aetiological formulations. This reinforces the notion that culture exerts an important influence on causal attributions and that diagnosis and/or the severity of the symptoms being experienced by the individual also changes these perceptions.

Two of the other studies worthy of mention in the current context are those of Joseph Westermeyer and Ronald Wintrob (1979), and of Gerald Resner and Joseph Hartog (1970). These were among the first psychiatric anthropological studies of lay people's causal beliefs about mental disorder. Resner and Hartog spent two years in urban and rural Malaysia collecting causal concepts about mental disorder. They found that their informants held similar causal beliefs to those held by lay people in the West. These beliefs included such things as heredity, congenital difficulties, stress, and contagion. They were surprised at the parallelism between both the urban and rural Malay beliefs and those of members of Western cultures. While they acknowledged that the Malaysian people held supernatural, physiological and environmental causal beliefs not found in the West, they suggested that their findings indicate that there are certain universal concepts about mental disorder that transcend cultures.

Westermeyer and Wintrob (1979) examined folk explanations of mental illness in rural Laos. They found that the rural Laotians held views that varied from supernatural causes to social problems and psychological states. One of the most interesting findings was that "in most cases [the informants] attributed responsibility for the ... condition to factors outside the control of the subject or the subject's family". The explanations elicited for the causes of mental disorder tended to ensure that the burden of responsibility would not preclude social support to the principal sufferer or the family. This supposition is consonant with that offered by Kleinman (1986). He saw

neurasthenia as a more socially acceptable mantle for depression that constituted a form of social discourse eliciting supportive social responses without casting the victim in a negative light. This is also congruent with the notions inherent in attribution theory regarding individual and social responses and the assignment of responsibility for mental illness. To wit, if the cause of mental illness is believed to be outside the sufferer's control, social attitudes will be more favourable and support would be more likely than if the cause is seen as being within the sufferer's control.

Causal Beliefs About Mental Disorder in Chinese Populations

Very few studies have examined exclusively Chinese lay theories of mental disorder. Luk and Bond (1992) replicated Furnham and Henley's (1988) study. They examined the beliefs of Chinese in Hong Kong about the causes and cures for ten different problems. This was done to determine the nature of, and the relationship between cause and cure attributions. They also included four social problems and two psycho-physiological problems that were considered somewhat more peculiar to the Chinese context.

The additional social problems investigated by Luk and Bond included: using the back door (corruption), child abuse, lack of civic responsibility, and social apathy. More important in the current context was their inclusion of neurasthenia. Neurasthenia is considered by Chinese to be biologically based, while most of the other problems are considered as forms of social deviance.

There were several very interesting findings in Luk and Bond's study. Their factor analysis revealed only two factors for the 26 cause attributions and three factors for the 36 cure attributions. The first causal factor labelled 'environmental/hereditary' included such causes as genetic predisposition, brain or nervous system problem, bad work

environment, supernatural beings, discord with family or friends and lacks willpower. The second causal factor was labelled 'social-personal' causes and included attributions such as caused by some other deep-rooted problem, lacks correct information about the problem, low quality of life, interaction with others having the same problem and lacking religious beliefs.

Luk and Bond's (1992) cure factors were labelled commitment, clinical methods and protection. The commitment factor loaded significantly on cure attributions such as obtaining help (from family, friends and colleagues), how hard the person tries or believes that the problem can be overcome, willpower, avoidance of things that make the problem worse and how much courage the person has to change. Items that coalesced under the 'clinical methods' factor reflected such things as whether the person gets professional help, how much power the person's body has to recover from diseases, improvements in the person's home or work environment and reductions in workloads. Finally, the 'protection' cure factor subsumed items such as how intelligent the person is, how much s/he believes in God, and how much formal education the person has.

The Luk and Bond (1992) results stood in sharp contrast to Furnham and Henley's five-factor solutions (Furnham, & Henley, 1988; Henley, & Furnham, 1988) for cure attributions among British subjects. Luk and Bond speculated that the different factor structure was indicative that their Chinese lay subjects held a more *interactional* view of the causal and cure mechanisms underlying psychological problems than their British counterparts. In other words, Chinese subjects did not distinguish causes and cures along such discrete internal/external or biological/psychological lines.

Luk and Bond found strong consensus regarding the curative efficacy of 'commitment' across all of the problems including those considered to be psycho-physiologically based.

Where the British subjects endorsed outside, 'professional' help in particular, as crucial for overcoming psychopathological problems, the Chinese subjects rated internal constitutional and 'self-help' factors as more important in causing and curing psychological problems.

Sinclair (1994) replicated and expanded Luk and Bond's study. That study was an exploration of lay beliefs of Chinese from the People's Republic about an expanded set of problems. Among the principal findings were more complex factor structures for both the causes and cures (seven and eight factors respectively) than those found by either Luk and Bond or Furnham and Henley. Further, these factors were not as clearly interpretable as those found in any of the earlier studies.

This complexity of factor structures could have been an experimental artefact possibly due to the inclusion of a greater number of, and a more heterogeneous set of psychological problems. A second difficulty with the Sinclair study was that the sample obtained was very highly educated (primarily masters and doctoral students studying at the University of Alberta). This would have restricted the variance of responses and therefore made factor analysis less useful in arriving at a clear underlying structure.

However, with regard to neurasthenia, Sinclair's (1994) descriptive statistics of subjects' endorsements of the 26 causes and 36 cures revealed a structure that was conceptually consistent with that found by Luk and Bond (1992). With regard to this disorder, Sinclair found that Chinese subjects endorsed internal and external, physiological and psychological cause and cure attributions nearly equally. This suggested that these subjects also held an interactional view of both cause and cure for neurasthenia. In other words, they did not differentiate between various types of causes and cures as had subjects in the Furnham and Henley studies conducted in Britain. This seemed to lend

support to the notion that Chinese lay people hold distinctly different, and more interactional, conceptualisations of psychological problems than those held by lay people in the West.

Using an ethnographic approach Pearson (1993) examined the causal beliefs about mental illness held by psychiatric patients and their family members presenting at a Shashi city psychiatric hospital in Hubei province of China. She used an open-ended interview format to elicit causal explanations for the presenting problems of 37 patients and their accompanying family members. The problems of patients interviewed ranged from psychotic disorders (e.g., schizophrenia, bipolar disorder) to family conflict oriented difficulties. While Pearson also asked about help seeking, her discussion focussed on causal explanations. The major finding with respect to help-seeking suggested that rural residents frequently sought the help of shamanistic healers whereas urbanites tended to eschew such assistance.

Pearson (1993) found that her interviewees endorsed primarily psychosocial and supernatural causes. The chief cause of disorder cited by her subjects was personality factors of the patient. This was closely followed by social problems such as family conflict and financial worries. Additional social causes included conflicts at work or school and problems with members of the opposite sex. Roughly 40% of relatives suggested that supernatural intervention was the basis for the patient's problems. It was interesting that less than 20% of the responses reflected somatic explanations and only one person suggested that their family member's problem was associated with genetic causality.

Pearson noted that the explanatory model of mental illness held by the patients' relatives was in stark contrast to the beliefs held by the practitioners with whom she

conducted the interviews. These doctors held primarily biomedical causes to be responsible for the mental disorder of these patients and rejected psychosocial causal explanations. Pearson argues that this indicates a significant need for modifications to medical education to include more psychosocial understanding of mental illness and that Chinese families need much more attention, information and support from physicians since families are the primary providers of care for mentally ill persons in China.

Causal Beliefs About Depression

Among the earliest and most widely cited examinations of 'lay' theories of depression was the series of studies conducted by Vicky Rippere (1977a, 1977b, 1977c, 1979, 1980a, 1980b, 1980c, 1980d, 1981a, 1981b). Several authors (e.g., Kuyken, Brewin, Power, & Furnham, 1992) have criticised these studies as not reflecting actual lay beliefs. The main reason for the criticism is that all of her 'lay' samples included (and some were totally constituted of) undergraduate and graduate students in psychology, and an array of medical doctors, psychologists, psychiatrists and social workers. In other words, many of her subjects were likely highly knowledgeable about mental health and would have scientifically or professionally informed ideas about the subject of depression. None of these samples could realistically be said to represent the naïve or 'lay' perspective with respect to depression. Thus, it is unlikely that their opinions etc. would reflect the 'common stock of social knowledge' about the disorder.

This criticism is valid with respect to the studies in which Rippere purports to tap 'common sense' or 'every-day' understandings of depression. However, in her earlier studies Rippere (1977b) states that she deliberately used undergraduate psychology students, the "most frequently tapped sources of psychological data" (p. 58) to point out that even without extensive training they already possessed sophisticated knowledge of

depression. Her point being, that the a priori 'everyday' knowledge undergraduate students possess is not taken into account by other depression researchers employing such subjects and may, consequently, compromise the validity of their studies. It could be added in this context that Rippere herself failed to take into account the degree to which these students knowledge may, given their area of interest, have been informed by formal theories acquired prior to attending university.

A second conceptual and methodological shortcoming is that nowhere in any of her studies of depression, does Rippere define the term for her subjects (or her readers). However, her discussions suggest, it is the (formal) 'disorder' depression with which these studies are concerned. Therefore, it is equally likely that people in her studies may have been generating, reacting to, or rating these 'common-sense' ideas about the emotion, the symptom, the illness and/or the disease of 'depression'. In this respect, Rippere's work serves more to obfuscate than inform our understanding of lay theories of depression.

Given these caveats, below is a brief summary the collective findings of the Rippere studies. Rippere asserts that lay people have a significant and accurate body of knowledge about:

1) how often people get depressed

2) how depressed they usually are when they say they are depressed

3) how long the feelings of depression will last

4) what sorts of things make them feel more depressed

5) how often they try to do something about feeling depressed

6) how often they find what they do helpful

7) the type of strategies people will employ to mitigate their depression

8) how useful they find these strategies

Rippere further suggests that this knowledge extends beyond personal information to the prediction of other's information and/or attitudes about depression. While Rippere may have committed some methodological and conceptual faux pas, she succeeded in stimulating a new avenue of research for subsequent scholars in the study of depression.

Given some of the later findings (discussed below), it may also be suggested that, at least in the West, lay people hold causal theories of depression that are highly congruent with those currently held by health care professionals. With the rapid proliferation and dissemination of information in the various popular media, it is likely that a significant proportion of the lay public has had some exposure to academic theories of depression. In as far as this is true, Rippere's work does shed some light, albeit circuitously, on true 'lay' causal theories of depression.

Caro, Miralles and Rippere (1983), and Miralles, Caro and Rippere (1983) conducted a cross-cultural replication of two of Rippere's studies (Rippere, 1977b; Rippere, 1980, respectively). They compared Spanish lay person's ideas about 'what to do when feeling depressed' and 'what makes depressed people feel worse', with those of the original British samples. While the former study would perhaps be more appropriate to the section on help seeking research (below), for the sake of coherence the two studies are presented together.

Caro, Miralles and Rippere (1983) reported that the British subjects produced a greater number (731) of responses than did the Spanish subjects (137) to the question 'what is the thing to do when you feel depressed'. There was a much higher ratio of consensual (items mentioned by more than one subject) to non-consensual responses (items mentioned by only one subject) among the British group (87.2% consensual to 12.8% non-consensual) than their Spanish counterparts (25.0% consensual to 75.0% non-consensual).

As might be expected from the sheer numbers of responses, an analysis of the items into superordinate categories also revealed a wider scope in the British sample's responses than in those of the Spanish sample. British subjects produced antidepressive behaviours that resolved into seven loosely defined conceptual groups called: Activity and work; Self-care and maintenance; Pharmacological; Cognitive and affective experience; Aesthetics, entertainment and contemplation; Help and comfort seeking; and Avoidance. By comparison, the Spanish group produced responses fitting into only three major categories (Activity and work; Cognitive; and Help and comfort seeking).

An analysis of the items overall revealed significant overlap among the most frequently cited antidepressive behavioural alternatives across the samples. Caro, Miralles and Rippere suggested that this reflected a "core of antidepressive behaviour which crosses the particular [cultural and linguistic] boundaries in question" (p. 481). The non-overlapping items showed that the British sample included a greater number of 'qualifiers' (e.g., 'it depends on what is causing the depression' or 'it depends on how depressed one is'). A second difference in the non-overlapping items was the emphasis on different forms of avoidance. The British subjects suggested avoiding different people, places or situations that may be depressogenic, whereas the Spanish subjects preferred to simply avoid thinking about being depressed. One conclusion to be drawn

from this result is that the British subjects emphasised external (e.g., environmental manipulations) means of overcoming depression, while the Spanish subjects felt that depression could be overcome through cognitive means (e.g., simply changing one's thinking).

Regarding factors that exacerbate depression, Miralles, Caro and Rippere (1983) reported results similar to those of Caro, Miralles and Rippere (1983). The British sample produced a greater number (351) of responses than did the Spanish sample (86) to the question 'when you are feeling depressed, what sort of things can make you feel worse'. As with the first study, British subjects showed a higher ratio of consensual (61.9%) to non-consensual (38.1%) responses than did their Spanish counterparts (20.4% consensual to 79.6% non-consensual).

The authors suggest that the greater number of responses and the consensus evidenced in the British sample may reflect a more extensive and more organised body of common-sense knowledge of depression in this population than among the Spanish. They speculate that this may be due to the long tradition in English literature of speaking about issues of dealing with depression, versus a relative poverty of such references in the Spanish literature. They also postulated that the greater number of self-help style books (e.g., popular home medical guides) in Britain versus Spain may have led to a wider availability among the British subjects of concepts about what to do and what not to do when depressed.

Since the replications do not provide detailed information (e.g., level of education, occupation, etc.) about the Spanish samples used, it is not possible to determine the effect of such characteristics on the data reported. However, it is possible that if the Spanish sample was not constituted of health professionals (as were the two British

comparison groups), this could account for the very wide discrepancies reported. In other words, if as a result of education and professional orientation the Britons had extensive knowledge of depression and the Spanish did not, then the effects seen in the data would be an artefact of the sampling procedure rather than true cultural differences in knowledge of depression. Unfortunately, given the paucity of specific information in these two articles, this question remains unanswerable.

Following Rippere's lead with a somewhat stronger conceptual and methodological approach to the topic[9], Furnham and Kuyken (1991) surveyed British lay people and had them rate 32 causal attributions and five current scientific theories about the cause of depression. Using factor analysis the 32 causes resolved into six factors. These included social deprivation, interpersonal difficulties, traumatic experiences, affective deprivations, negative self-image, and interpersonal loss. Their subjects showed a relatively strong consensus regarding the influence of these six factors and in their endorsement of the scientific theories. In terms of the academic theories, subjects most strongly endorsed cognitive and learned-helplessness causal theories of depression and they rated biological-genetic and behavioural theories lowest.

Interestingly, those who had reported a prior episode of depression rated 86.5% of the 32 attributions as more important than those who reported no prior experience of depression (27.8% of these rating differences reached statistical significance). Items that differentiated most significantly between the two groups were such things as being lonely, lacking friends and difficulties with their 'significant other'. Overall, the loss of a

[9] These authors provided subjects with a clear description of what the term 'depression' was referring to in the context of the study. They employed a true 'lay' sample to derive items to be included in their questionnaire. Finally, 86.1% of their sample was constituted of individuals with no formal training related to depression and the data from the remaining 13.9% of the sample, subjects who had extensive professional knowledge of depression, was analysed separately.

spouse, rape and discovering one had a terminal illness were rated highest by these lay subjects as a causes of depression.

Furnham and Kuyken (1991) found that the causal explanations, as generated and endorsed by these lay people, contained many components that are consistent with academic theories of depression (e.g., learned helplessness and cognitive theories). Further, previous experience with depression had a significant impact on subjects' ratings of the various causal attributions.

One year later, Kuyken, Brewin, Power and Furnham (1992) examined the beliefs about depression held by depressed patients, clinical psychologists and lay people in Great Britain. These researchers found that depressed and non-depressed lay people held very similar beliefs about the causes of depression to those of clinical psychologists. These causes included such things as biological factors, response to loss, unfulfilled desires-hopes-ambitions, childhood difficulties, etc.

Among Kuyken et al's (1992) principal findings was, that depressed patients were more likely than either clinical psychologists or non-depressed lay people to endorse biological theories of causality. They also found that while clinical psychologists believed that childhood factors and unconscious factors were important causes of depression, they were less likely than depressed or non-depressed lay subjects to endorse the utility of psychodynamic interventions. On one hand, this latter finding may simply reflect a predilection among psychologists toward cognitive-behavioural techniques in the treatment of depression because of their training. On the other hand, it suggests that while psychologists may endorse a particular causal mechanism in depression, such beliefs do not necessarily dictate their therapeutic approach.

Kuyken et al (1992) suggested that the high endorsement of biological causality by depressed patients might relieve them of responsibility for the cause and/or cure of their disorder and justify their acceptance of pharmacological interventions. Conversely, they also surmised that this preference for biological causal beliefs might have resulted from patients having been given biological explanations of their depression by helping professionals as rationale for being given antidepressant drugs to alleviate their symptoms. Thus, it is difficult to disentangle the cause and effect relationship between beliefs and other factors such as treatment history. In this connection, it would be interesting to observe whether depressed patients treated exclusively with a particular intervention (e.g., psychodynamic, or cognitive, or pharmacological therapies) would show a different preference for causal explanations as a function of the therapeutic approach.

In sum, methodological considerations aside, the research on causal beliefs reveals several things. First, as with mental health problems generally, lay people have an extensive, sophisticated and relatively consensual understanding of the causal mechanisms at play in depression that is not very different from that contained in current academic theories. Second, culture seems to play a significant role in shaping this corpus of knowledge. Third, and finally, the experience of depression itself, and/or the therapies applied to depression may play a significant role in shaping lay beliefs about what causes depression.

Help Seeking Research

Many studies have addressed the issue of help seeking. Most of the early research focussed on help seeking preferences or behaviours of immigrants or minority groups compared to those of a particular host population. These were primarily 'utilisation'

studies examining epidemiological and hospital/clinic admission data. They focussed on help seeking patterns in order to contrast utilisation of mental health resources among the various groups under study. Later studies were conducted primarily within homogeneous populations using ethnographic or survey methods. These studies were undertaken to tease out how particular factors such as somatisation, patient attitudes, availability of mental health services, culture, and/or type of setting may influence help seeking by a given group.

Another differentiating feature in this body of research is the underlying questions the researchers meant to address. The utilisation studies focused on the question of whether or not there was a pattern of under-use (or over-use) of mental health services by a particular segment of the population. This research was targeted at the question of utilisation, more or less in isolation from the reasons for it. The questions often addressed by the more 'ethnographic' studies that focus on beliefs was 'if not mental health services, then where are these people going for help' and 'why may there be a preference for a particular source'. In the utilisation studies, researchers simply speculated about the reasons for under-use of mental health resources. The ethnographic studies addressed these reasons more directly. In this section, I review some of the utilisation-type studies, however, I will focus primarily on the latter studies because of their emphasis on, and elucidation of factors such as belief systems and their influence on help seeking.

Help Seeking in Non-Chinese or Mixed Populations

In one of the more comprehensive cross-cultural examinations of mental health service utilisation in the US, Snowden and Cheung (1990) reviewed evidence from large-scale epidemiological research and found significant differences based on race and ethnicity.

They reported that African-Americans and Native-Americans were more likely than White-Americans to be hospitalised for psychiatric disorders. African-Americans, more than Whites, received diagnoses of schizophrenia. The reverse was true for diagnoses involving affective disorders. While Asian-Americans were less likely than whites to be hospitalised, they remained in hospital for longer periods of time. Snowden and Cheung speculated that such differences in utilisation might have been due to several factors. These included such things as differences in treatment careers, socio-economic status, rates of psychopathology, help seeking strategies and culturally-based biases in diagnoses. In Snowden and Cheung's analysis, no single factor was viewed as dominant. Instead, they pointed to the likelihood that these factors probably interacted to produce the observed differences, and that research into the effects of each, separately and in combination, was needed. This study focussed purely on patterns of utilisation and only speculated as to the reasons for these patterns.

In one of the first studies of its kind, Sue (1977) examined the patterns of help seeking and mental health service utilisation by members of minority groups in Seattle. He found that African-Americans and American Indians overused mental health services by comparison with their Asian-American and White counterparts. Asian-Americans were found to use mental health services least often and, as with the other non-white groups (even when demographic and socio-economic characteristics were held constant), dropped out of therapy after a only one session in about 50% of the cases (compared with 30% rate for White Americans).

Sue (1977) speculated that the observed differences were a function of several factors. On one hand, some of the under-utilisation may have been accounted for by non-client variables such as mental health professional's perceptions of and reactions to minority clients, patterns of diagnoses and approaches used in treatment. On the other hand, Sue

suggested that these differences could also be explained in terms of patient and family problem definition, differential tolerance of deviant behaviour and actual or perceived stigma associated with mental illness among the various groups studied. Most significantly, the results of this study emphasised the influence of culture in the help seeking and therapy processes. Sue asserted that client therapist match in areas such as race and language, and therapist training in multicultural awareness was needed in order to improve service delivery to ethnic minority clients in the United States.

Sue, Fujino, Hu, Takeuchi and Zane (1991) replicated and extended the Sue (1977) study. They found that the effects of ethnicity on the utilisation of mental health services had persisted, although the effect was somewhat attenuated. Perhaps more importantly, they found partial support for Sue's (1977) assertions regarding client-therapist match. They found that matching therapist and client for ethnicity and language (for ESL or non-English speaking patients) significantly predicted a lengthier stay in therapy and, in part, positive treatment outcome for minority-group patients.

Lin, Tardiff, Donetz and Goresky (1978) conducted one of the first studies of help seeking behaviour that included Chinese subjects in Canada. Their study was retrospective and examined the pathways travelled by Anglo-Saxons and middle-Europeans, Chinese, and First-Nations patients to psychiatric treatment. The principal findings of their research were that the Anglo and European patients were referred earliest, and to multiple sources of mental and social help. Of the three groups, the Chinese remained sequestered within the family for the longest time. They sought, or were referred by family members for, psychiatric help latest in the progression of their disorder when the prognosis for swift and complete recovery was poorest. Chinese with mental disorders were also first referred to multiple sources of medical help before finally reaching psychiatric treatment. The First Nations group was intermediate,

between the Anglo-Europeans and the Chinese, in terms of where in the progression of disorder they received psychiatric help and were principally referred for psychiatric treatment by outside agencies. The results of this study added to the mounting evidence for a significant role of ethnicity in help seeking. It also linked in a more substantial way the perceptions and tolerance of mental disorder, and of the patient, to the pathway to psychiatric help. Chinese families were willing to tolerate exceptional levels of deviant behaviour before seeking outside help for their mentally ill members.

Lin, Inui, Kleinman and Womack (1982) employed semi-structured interviews and questionnaires to examine the socio-cultural factors that influence help seeking among White-, African- and Asian-Americans. They conceptualised the help seeking process in two interrelated ways. The first involved viewing help seeking as a process that involved two stages: 1) the time from onset to first contact with mental health professionals (termed 'contact-delay'); and 2) the time from onset to entry into treatment (termed 'treatment-delay'). The second involved conceptualising help seeking in terms of three patterns. Pattern A was characterised by persistent involvement of family, traditional health care methods, community leaders/resources and reluctance to accept psychiatric help. Pattern B was characterised by early self or family referral, multiple contacts with general and mental health providers, and utilisation of psychiatric services. Pattern C was characterised by utilisation of mental health services with referral by legal or social agencies (Lin, Inui, Kleinman, & Womack, 1982, p.79). The reader will notice that this latter tripartite conceptualisation of the help seeking process is the same as that defined by Lin, Tardiff, Donetz and Goresky (1978) in their Canadian study.

The most striking finding in this study was the influence of ethnicity on the pathway to psychiatric services. Asian patients were predominantly categorised as following the pattern A pathway. White-Americans were found to follow pattern B. African-

Americans were equally likely to follow pattern B or C. This study supported and extended Lin, Tardiff, Donetz and Goresky's (1978) Canadian findings regarding ethnicity and help seeking. It further reinforces the notion that Asian ethnicity is significantly related to a propensity toward alternative sources of help for mental health problems.

Hall and Tucker (1985) examined the relationship between ethnicity, beliefs about mental illness and attitudes toward seeking psychological help among 513 African-American and White-American school teachers. They elected to examine the attitudes of teachers because they "are in a position of influencing attitudes and behaviors of the masses" (p. 908).

Hall and Tucker's (1985) results revealed some significant similarities and differences associated with race. They found that their White-American and African-American subjects did not differ in their attitude toward seeking psychological help. However, roughly twice as many White-American (27.41%) than African-American subjects (14.58%) reported having done so. The study also revealed some significant differences in their subjects' conceptions about mental disorder. White-American teachers held views more congruent with those of mental health professionals than did their African-American counterparts. Hall and Tucker suggested that the significantly greater tendency among their African-American teachers to endorse willpower as a cure for mental illness may indicate that these subjects would have difficulty in adopting the role of client since it may be perceived as a sign of personal weakness.

Sussman, Robins and Earls (1987) focussed on help seeking, specifically for depression, among African-Americans and White-Americans. Using epidemiological data on depression, they examined the relationship between help seeking and symptom severity,

attitudes and beliefs about depression and therapy. When it came to severe, prolonged and/or frequent depressive symptoms, there was no difference in the likelihood that either group would seek professional help. However, fewer of the African-Americans who met the research criteria for a diagnosis of depression had sought such assistance. Concomitantly, African-Americans, overall, were less likely than their White-American counterparts to evaluate a problem as relevant for professional help.

Sussman, Robins and Earls (1987) speculated that social comparison might have played a role in the lower propensity of African-Americans to construe a problem as warranting professional intervention. The implication is that, on average, the less severe symptoms of depression may be less salient and, thus, more tolerated in the African-American community due to their higher prevalence among members of this population[10]. Similarly, they reported that their data suggested it was fear of treatment and hospitalisation, more than fear of stigma, which prevented African-Americans from seeking help.

Help Seeking in Chinese Populations

There is a relative paucity of research examining help seeking in Chinese populations outside of North America. Unlike the research reviewed for non-Chinese and mixed populations, an exhaustive search of the literature failed to uncover studies that used an

---

[10] A major difficulty exists with the social comparison-prevalence argument posed by Sussman, Robins and Earls (1987). That is, one would expect social comparison to play a similar role in limiting the propensity to evaluate depressive symptoms as warranting professional intervention in other populations in which depressive symptoms are similarly prevalent. This does not seem to be the case. For example, there is a wide literature supporting the notion that women are about two times more likely than men to experience depressive symptoms (see Kaelber, Moul, & Farmer, 1995 for a comprehensive review). However, in our society women are more likely than men to seek help for depression (Brems, 1995; Horwitz, 1977). Therefore, it seems more likely that African-Americans may be generally more tolerant of the low-level symptoms of depression than their White-American counterparts. In either case, it seems clear that culture and the level (severity, persistence and frequency) of symptoms plays a significant role in whether an individual will seek help to overcome depression.

epidemiological approach to examine help seeking or mental health service utilisation within exclusively Chinese populations. The studies described below principally use the ethnographic approach mentioned above and address the help seeking question from several different perspectives.

Ying and Miller (1992) examined the help seeking behaviour and attitudes toward psychological problems among a community sample of Chinese-Americans as mediated by their acculturation level, demographic characteristics and mental health status. They found a significant effect of several variables on actual help seeking and on attitude toward seeking mental health services. Among the 13.3% who reported having sought mental health services, a greater numbers of physical symptoms, coming close to experiencing a nervous breakdown at sometime, having a family member being treated for a psychological disorder and being American born most strongly predicted accessing mental health services. A positive attitude toward seeking mental health services among those who had not done so, was most strongly predicted by subjects having higher English ability, being younger and married and by a lower SES.

Ying and Miller (1992) concluded that attitude toward help seeking reflected a more general propensity rather than an accurate predictor of who would and who would not seek out mental health services. In addition, attitude exerted less influence than the presence of need (as reflected in having more symptoms) on actual help seeking behaviour. In other words, when need was present the other characteristics of the individual became less influential in determining help seeking behaviour. While both showed a positive relationship with help seeking, it was interesting that the presence of physical symptoms was such a strong predictor of help seeking compared to the level of depressive symptoms (measured by the CES-D).

This tends to support the widely reported somatic symptom component among Chinese with psychological problems. In this regard Ying and Miller (1992) suggested that this finding illustrates the significant need for closer co-ordination between mental health professionals and front line medical practitioners in providing appropriate and effective mental health interventions to their Chinese patients. In addition, acculturation level, in the form of English fluency and being American born, also influenced behaviour and attitude, with greater acculturation having a positive impact on both. Thus, it was suggested that mental health education might be best directed at venues such as the ESL classroom (Ying, & Miller, 1992).

To examine the perceived problems and help seeking preferences of Chinese immigrants in Canada, Christensen (1987) created a questionnaire that addressed 43 different problems understood to affect this group. None of the problems included in the questionnaire could be clearly defined as psychiatric disorders. Rather, the questionnaire primarily consisted of interpersonal problems (e.g., marriage/love relationships, problems with children, language problems) and some items that may be symptomatic of psychological disturbance (e.g., don't want to go on living, feeling worthless/useless, problems sleeping/bad dreams).

Briefly, Christensen (1987) found that, for the majority of subjects, family or friends were the preferred sources of help for both psychological and interpersonal problems. The survey also revealed that males would choose other family members (members of extended family) and females would choose friends as their second option when looking for assistance.

Several authors (e.g., New, & Wagson, 1983) have suggested that Chinese immigrants in Canada and elsewhere are likely more in need of psychological services due to the

pressures of immigration and of minority status. The group studied by Christensen (1987), had been in Canada for an average of 9 years, and 27% said that they were aware of 'mainstream' services. Although they were in the minority, some of Christensen's subjects indicated that they had experienced problems that are symptomatic of depression (e.g., feeling powerless, feeling of 'going crazy', don't want to go on living, feeling worthless/useless, problems sleeping). For such problems, family and friends were the preferred resources when subjects indicated they would seek help. For several items such as 'alcohol or drug problems' or 'feeling of going crazy', over 60% of Christensen's subjects indicated that they would not go to anyone for help. Thus, for this group of Chinese people, the findings are consistent with those seen in other studies. Family and friends are the first, and in some instances, the only source of help they would consider, even for problems that are suggestive of severe psychiatric difficulties. Mainstream services, for whatever reason, are considered either not appropriate, not effective and/or undesirable by those experiencing significantly debilitating symptoms.

Cheung and Lau (1982) examined the influence of setting on Hong Kong Chinese subjects' verbal reports of symptoms and previous help seeking behaviour. The main objective of the study was to determine if the setting in which the patients were seen influenced their tendency to emphasise somatic or psychological symptoms during consultation (verbal help seeking behaviour). However, they also examined the helping resources subjects had approached prior to attending the particular medical setting involved in the study. They interviewed new cases at a hospital psychiatric outpatient clinic (n=75), a prison psychiatric observation unit (n=80) and a general medical outpatient clinic (n=37).

In the context of the current research, two categories of Cheung and Lau's (1982) findings are most germane. First, they found that while the majority (64%) of psychiatric outpatients presented with somatic symptoms as their principal reason for consultation, only 26.7% presented somatic symptoms exclusively. The remainder of the sample presented mixed somatic and psychological symptoms or psychological symptoms exclusively. On the other hand, the prison psychiatric clinic attendees presented almost exclusively psychological symptoms (80.8%) and none presented somatic symptoms exclusively. As would be expected, the general medical clinic subjects cited almost exclusively somatic symptoms as their reason for seeking help. Only 8.1% of this group presented a mixture of psychological and somatic symptoms.

Cheung and Lau (1982) suggested that this finding was evidence of a significant effect of setting on patients' verbal help seeking behaviour. Patients at the general medical clinic would expect help for, and therefore express only somatic concerns. Those attending the prison psychiatric facility were not expecting help for, and therefore did not express somatic concerns. In terms of the psychiatric clinic, the situation would be perceived as somewhat ambiguous. This was a medical setting staffed with medical doctors. However, it was a setting geared toward treating mental or psychological difficulties. Cheung and Lau believed that this might have been why these subjects described a mixed set of symptoms including psychological and somatic concerns.

The second, and perhaps more germane, aspect of Cheung and Lau's (1982) findings was the pattern of previous help seeking behaviour described by the psychiatric outpatients. This was dominated by consultations with Western medical doctors (73.3%) followed by Chinese herbalists (29.3%) and Chinese worshipping (12.0%). Acupuncturists were cited as a source of consultation by only eight percent of these patients and, remarkably, friends were previously consulted by only 2.7%.

Also worth mention is the fact that, consistent with findings of other studies (e.g., Lin, Tardiff, Donetz and Goresky, 1978), the Chinese psychiatric patients studied by Cheung and Lau (1982) were a long-suffering group. Over half of them had suffered with their symptoms for over one year, and nearly ten percent had endured for over nine years before seeking psychiatric help for the first time. These subjects followed a circuitous and often lengthy path to psychiatric help that could be characterised as a pattern A in Lin's typology.

It is important to remember that Lin, Tardiff, Donetz, and Goresky, (1978) and Lin, Inui, Kleinman, & Womack, (1982) conducted their studies in Canada and the US (respectively). The availability of mental health services in these two settings is much greater than in Hong Kong (Cheung, 1986) where Cheung and Lau did their research. The fact that this pattern is repeated in an entirely different social context is interesting. It suggests that the pattern A help seeking approach may be more a function of Chinese culture (e.g., general reluctance to admit or seek help for psychiatric problems, social stigma, etc.) and/or a lack of familiarity with available mental health resources than with their actual availability.

Fanny Cheung (1984) also examined the help seeking preferences of Chinese university students in Hong Kong in relation to the type of problem for which help is sought. She presented her subjects with the 22 problems on the Langner scale (Langner 1962, cited in Cheung 1984) and had them rate the degree to which they would be willing to seek help for each problem. The problems on the Langner scale were later categorised into four groups: psychological, psychophysiological, physiological and ambiguous. She also asked them whom they would consult for help for each problem. Subjects' responses regarding sources of help were categorised into seven groups: family, friend/schoolmate,

teacher/adviser, religious personnel, doctor, or mental health professional (psychiatrist, psychologist or social worker).

Overall (Cheung, 1984) found that these students were not likely to seek help from outside sources. On all but two of the problems, more than 50% of the students indicated their unwillingness to seek help. For those students who said they would seek help for their problems, medical doctors were preferred. Females were more likely to than males to seek help from friends and family. For a small subset of problems, males, more than females, showed a marked preference for medical doctors as sources of help. For all categories except psychological problems, family was rated intermediate (though low) between medical doctors and friends in level of preference.

For psychological problems, friends were the most frequently cited resource of preference. Cheung (1984) suggested that this preference for friends' help with psychological problems might reflect the developmental stage of these primarily young undergraduate students. Across all categories of problems, mental health professionals were the least frequently cited source of help. Again, this could be a function of lack of familiarity with or general reluctance to seek such help.

Cheung's (1984) results strongly reinforce the notion that the perception of the cause or nature of the problem exerts a significant effect on the resources that people are willing to approach for help. If the assertion of Kleinman (1986) and others regarding the Chinese tendency toward a somatic conceptualisation of depressive illness is even partially valid, it is likely that this would predispose Chinese patients to seek biomedical help for depression.

Examining a different population and context, Cheung, Lau and Wong (1984) studied the pathways that psychiatric patients took to arrive at either a private or a public psychiatric clinic for consultation. There was a significant difference in the nature of problems prominent at each clinic. The public clinic treated a majority of individuals experiencing problems with more florid and persistent symptoms (e.g., schizophrenia), while the private clinic seemed to attract patients experiencing problems with symptoms that, while still debilitating, were somewhat less overt and often followed a more variable course (e.g., neurotic depression).

Cheung Lau and Wong's (1987) subjects reported a widely varying array of help seeking patterns. In terms of their initial ways of coping, the main finding was that patients in the private clinic were more likely than their counterparts in the public clinic to attempt self-directed resolutions to their problems. Self-directed psychological approaches included such things as doing nothing, avoidance, and change in social lifestyle. Self-directed somatic approaches included such things as change in physical lifestyle and self-medication. A majority of public patients reported that they approached a professional (usually medical) resource in the initial phase of their help seeking, while only a minority of the private patients reported having done so.

In terms of the overall pattern of consultation with external resources, the vast majority of both public and private clinic patients reported they had consulted with Western medical doctors. Differences arose when other forms of outside help were examined. Traditional Chinese medicine was chosen by 21.4% of the private clinic patients, and by 15.5% of public clinic patients. The most dramatic difference in resource usage between these two groups of patients was in their use of folk religion (e.g., attending temples or consulting fortune tellers); 12.5% of private clinic patients but only 3.1 percent of public clinic patients utilised such resources.

While Cheung, Lau and Wong (1984) used only the public/private distinction to differentiate their subjects, it is important to note that help seeking patterns in this study may also have been fundamentally influenced by the various diagnostic categories and socio-economic status of the patients. It is very likely that the help seeking behaviour of individuals suffering from schizophrenia (more frequently seen in the public clinic) would be different from those with neurotic depression (more frequently seen in the private clinic).

Finally, individuals from higher socio-economic backgrounds in Hong Kong have a wider range of helping options available to them than do those from lower socio-economic status groups. Thus, it is not surprising that the private clinic patients pursued such options as TCM etc. with greater frequency than their public clinic counterparts. Given that such resources were not provided for in the public health system of Hong Kong, they would incur greater cost to the patient than would the Western medical treatments that were provided in the public system. Cheung, Lau and Wong (1984) made reference to the issue of availability and cost in contrasting their own findings with those of Kleinman (1982) (reviewed below) with respect to the utilisation of TCM and folk healing in China and Hong Kong.

Thus, the differences in patterns of help seeking seen in this and the other studies reviewed above cannot be viewed from a one-dimensional perspective. Instead, we must consider a wide range of factors as influential in shaping help seeking behaviours. The interplay of factors such as ethnic and demographic characteristics, socio-economic status, diagnosis, symptom severity and/or conspicuousness, treatment history, and causal beliefs, among others all must be taken into account when we try to predict where people with psychological problems will go for help. We will now turn to a

group of studies that attempt to take into account such interactions by examining both causal beliefs and help seeking.

Causal Beliefs and Help Seeking

The majority of the last group of studies reviewed here is closest to the current research because of the emphasis on the interaction of causal beliefs and help seeking. While they may, in some cases, take the utilisation research base as a point of departure, these researchers emphasise the phenomenological and survey approaches to the study of causal beliefs and help seeking. In so doing, it is believed that they come closer to illuminating the nature and the interdependence of these two aspects of the overall process as they relate to depression.

Causal Beliefs and Help Seeking in Non-Chinese and Mixed Populations

In an approach similar to that employed in the current research Narikiyo and Kameoka (1992) used a combination of vignettes and questionnaires to examine causal beliefs and help seeking preferences of Japanese-American and White-American university students in Hawaii. Their subjects read vignettes describing either a male or a female suffering from either schizophrenia or depression. Subjects were then asked to respond to three questionnaires about the cause of the disorder, the possible types of help and the sources of help that would be best for the person in the vignette. Finally, they were asked what sources of help they would use if they were experiencing the disorder in question and whether they knew family or friends who had accessed mental health resources. The

authors examined the effect of ethnicity, gender (of the character in the vignette) and severity[11] on subjects' causal beliefs and associated help seeking preferences.

Narikiyo and Kameoka (1992) found that, compared to their White-American counterparts, Japanese-American students were more likely to attribute mental illness to social or psychological causes. These included causes such as problems with other people, having a weak mind and keeping problems to him/herself. Interestingly, the White-American subjects endorsed physiological causes such as diet and heredity to a greater degree than Japanese-American subjects. Regarding the influence of severity of disorder, there was no difference between the two groups. Both Japanese and White American subjects saw psychotherapy, medication and the assistance of psychiatrists and psychologists as more important in overcoming schizophrenia than depression. The gender of the stimulus person did have an effect on subjects' ratings of causes and type of help. Physical illness was rated as a more important cause of the female than the male character's problems, and psychotherapy, change in diet and seeing a psychiatrist were rated as more important helping resources for the female character than they were for the male.

Finally, Narikiyo and Kameoka (1992) found that the Japanese-American subjects, more than their White-American counterparts, preferred resolving problems on their own, and to seek help from family members or friends. Both groups tended to endorse psychological or psychiatric sources of help for 'others' (i.e., the characters in the vignette) more than for themselves, and to rely, instead, on self, family, or friends for resolving their own problems. There were no differences between the two ethnic groups

---

[11] 'Severity' in this study was operationalised by the difference in the disorder presented in the vignette, with schizophrenia representing the most sever and depression a less severe disorder.

in their ratings of the helpfulness of mental health professionals (psychiatrist, psychologist, counsellor or social worker) when it came to the stimulus character.

An interesting feature of Narikiyo and Kameoka's (1992) results was the higher preference accorded 'herbalists' by the White-American subjects than that shown by the Japanese-American subjects. This could have been an artefact of the milieu and/or of the sample. On one hand, it is conceivable that these White-American subjects, residing in Hawaii, may have embraced many of what they perceive to be Asian or native Hawaiian cultural attitudes and practices such as herbal medicine. On the other hand, since these were university students, it may be that these young Japanese subjects rejected herbal remedies for fear of being viewed stereotypically.

Narikiyo and Kameoka (1992) hypothesised that the Japanese emphasis on harmony in social relationships may lead to the inclination to attribute social causation to mental disorder. They asserted that the greater tendency to stigmatise mental disorder, and the burden of responsibility for maintaining face likely leads to the propensity among Japanese-Americans toward resolving problems on their own and seeking help from family and/or friends before pursuing professional assistance. They also suggested that these factors likely influenced the significantly lower reported rates of mental health service utilisation (also found in the study) by the Japanese-American students.

While Narikiyo and Kameoka (1992) did not address the interaction issue directly, it is interesting that the subjects in this study were not differentiated, in terms of help seeking alternatives, as much by their ethnicity as on the severity of the disorder. In general, this seems to suggest a more robust effect of the perceived nature and/or cause of the disorder in question than of the ethnicity of the subject on help seeking preferences. However, the main effect of ethnicity on causal beliefs and on help seeking

attitudes (considered separately) was found to be very robust in spite of the fact that a large proportion of their Japanese-American subjects were third and fourth generation Americans (Narikio and Kameoka, 1992). This would seem to suggest that culturally shaped causal beliefs and help seeking preferences are relatively persistent in the face of acculturation.

If this is true then the mental health community in Canada should heed the findings of research in other countries and cultures, since many of these results may be relevant not only to recent immigrants but also to Canadian-born minority clients several generations removed from their immigrant progenitors. As will be seen below, however, some studies challenge the notion of the strong trans-generational influence of culture.

Furnham and Malik (1994) provided some evidence that raised questions about the notion of the persistence of culture's influence across generations. They conducted a study highlighting the effects of acculturation, or 'Westernisation', on beliefs about depression[12] and help seeking. Their sample included British women and Asian women (from the Indian sub-continent) of two broad age groups, 'young and middle-aged'.

Furnham, & Malik's (1994) results revealed that the middle-aged Asian women differed significantly from the other three groups (middle-aged British, young British and young Asian women) with respect to their beliefs about the causes of depression and about anti-depressive behaviours. The middle-aged Asian women, more than the other three groups, endorsed the statements "It is usually helpful to tell a depressed woman to 'pull

[12] It should be noted that this study suffered from the same difficulty earlier noted in relation to the research done by Vicki Rippere; the researchers did not provide a clear definition of depression. Therefore, it is not clear what subjects were responding to, the emotion or the disorder.

herself together and "When feeling depressed it is more helpful to talk it over with a family member" (Furnham, & Malik, 1994, p. 117). The nature of the beliefs endorsed by the middle-aged Asian women laid more responsibility on the depressed individual for the disorder and reflected the idea that depressed people should be able to get over the disorder with little or no outside help.

Furnham and Malik (1994) asserted that this was significant evidence of the influence of acculturation on such beliefs. They suggested that the difference in the level of acculturation was due to the fact that all but the middle-aged Asian women had received all or most of their education in Britain. Thus, the other three groups had spent a greater proportion of their lives exposed to the belief system of in British culture. They also found that the Asian middle-aged women were less likely than the other three groups to admit having been depressed, despite the finding that their scores were higher on the Langner scale of psychiatric morbidity. The authors suggested that this may have been because depression is more stigmatised in Asian culture than in British culture.

Whether there is an immediate effect of acculturation on beliefs about the causes of depression and help seeking preferences or behaviour is still open to question. Utilisation studies in Canada and the United States seem to indicate that there is a relatively persistent effect of Asian culture on help seeking behaviour. However, these studies have not conclusively answered the question of the degree of acculturation and its influence on these factors. What seems clear, however, is that culture exerts significant effects on these beliefs and that the causal beliefs, in turn, shape help seeking behaviour in demonstrable ways. In cultures that place more emphasis on such things as willpower, self-control of emotions and that stigmatise depression, individuals are more likely to attempt to cope with depression on their own or to turn to their immediate social support network for help.

Causal Beliefs and Help Seeking in Chinese Populations

As mentioned earlier, the studies reviewed below represent attempts at varying levels to integrate causal beliefs and help seeking. While several of these researchers did not address this interface directly, their results are such, that these linkages are more or less straightforward. Because of this salience to the current project, the following studies are reviewed in somewhat more detail than those described above.

In his landmark study of depression and neurasthenia in China, Kleinman (1982) conducted extensive ethnographic interviews with 100 neurasthenic outpatients at the Hunan Medical College. Eighty-seven of these patients were diagnosed, using DSM-III criteria, as suffering from Major Depressive Disorder. While it was not the focus of the study, he also examined patients' explanatory models of their disorder and their help seeking behaviours. While Kleinman did not conduct a systematic examination of the interaction between causal beliefs and help seeking behaviours, the data he presented is illuminating and relevant in the current context.

The vast majority of the 100 neurasthenic patients viewed their problem as either entirely organic or mixed organic and psychological in nature. A minority of patients viewed their problem as primarily psychological. Interestingly the majority of Kleinman's (1982) patients cited psychosocial aetiologies. Sixty-one percent cited work problems, political problems and problems associated with long separations from family (due to work assignments in different locales) were cited by 25% of the patients. Only a small minority attributed their problems to physiological factors, including nutritional (9%) and genetic (5%) causes. Kleinman noted that although these patients recognised the influence of psychosocial stressors in the aetiology of their problems, they believed that these stressors acted directly on biological functioning. That is to say, these patients

did not associate stress to disorder through a mechanism of a 'psychological to somatic' causal chain. Instead, they believed that the stress caused organic dysfunction, which in turn caused the negative psychological symptoms they were experiencing.

Kleinman (1982) also found some very interesting features of the Hunan patients' help seeking approaches. Eighty-five percent of the patients indicated that they attempted some form of self-treatment to overcome their disorder. Thirty four percent indicated that they used self-treatment exclusively at first. The treatments included special foods, diet, and tonics used by 76% of these subjects. Traditional Chinese and Western medicines were used by 51% and 18% (respectively) of those who self-medicated. Thirty-eight percent attempted to cope by using Western exercises, and 14% indicated they tried traditional Chinese exercises. When asked what form of treatment they wanted, 40% indicated that the choice of treatment was up to the doctor. Sixteen percent asked for TCM medicines and 12% wanted Western drugs. Only 3% of the patients requested psychotherapy. As Kleinman noted, this was consistent with the limited knowledge of such interventions associated with their limited availability.

Medical resources were prominent in the treatment histories of Kleinman's (1982) patients. Western physicians were consulted by 98% of the subjects, while 84% reported consulting TCM physicians. Seventy-six percent of patients indicated that they had primarily consulted Western physicians whereas 24% consulted primarily TCM physicians. When indicating the treatments they received in the preceding year, 58% indicated they had received sedatives, 47% benzodiazepines and 60% received principally TCM medications.

The combination of the various different treatment modalities is typical of help seeking in China. This can be attributed, in part, to the official sanctioning, and the wide

popular acceptance, of the integration of Western and Traditional forms of medicine. At the time of Kleinman's study, medical care was relatively inexpensive and widely available, particularly in the larger cities (Kleinman, 1986). For these patients this may have been a mixed blessing however. Kleinman noted that "as a group the neurasthenia patients demonstrated a degree of illness behavior that was considered excessive by local standards. They made on the average almost two visits to doctors per month, ... a high figure for patients at the Hunan Medical College" (1982, p. 155). It is likely that many of these patients experienced prolonged and inappropriate treatments that, at best, delayed their receiving timely and effective treatment, and, at worst, could have led to chronicity and/or iatrogenic problems, and presented a significant burden for families and the healthcare system.

Among the most interesting findings was that 23% of these patients indicated that they had accessed sacred 'folk' resources, and 14% indicated that they had resorted to consulting shamans, sorcerers and other religious experts in attempting to overcome their neurasthenia. These findings are remarkable for two reasons. First, the study was conducted in Changsha, a relatively large city, where one would assume that such resources would be less subscribed to by, ostensibly, more sophisticated urbanites. Second, due to the Chinese government's stern censure (at that time) of such practices, it is surprising that urban folk practitioners would be as prevalent as this result suggests (Kleinman, 1982; Li, & Phillips, 1990).

The final aspect of Kleinman's (1982) study that is relevant here involves the results found at follow-up. As part of their treatment, the patients diagnosed with depression were given antidepressant drugs. In addition, they were given an explanation of their disorder in terms of the biomedical model of depression and were asked to return for a follow-up session five to six weeks later. The 71 patients who attended the follow-up

were asked about their post-treatment help seeking, their perception of the current state and what they called their problem.

Kleinman (1982) reported that a full 82% of the returning patients felt that their symptoms had improved, 65% reported substantial improvement and 17% reported slight improvement. Nine percent of these patients indicated that they had seen no improvement in their symptoms and 10% felt their symptoms had worsened. These reports were reasonably consonant with the assessments of these patients by physicians who also gauged their symptoms at the time of follow-up. On the other hand, a substantial proportion of patients reported little improvement, no improvement or worsening in the family, work and other problems that had accompanied their depression. In this regard, Kleinman asserted: "these findings would seem to indicate that although antidepressant drugs may have significantly benefited symptoms, they frequently did not have a major effect on illness problems. ... This ... demonstrates that medical treatment without significant psychosocial intervention exerts only a limited effect on the overall sickness" (1982, p. 164).

Sixty three percent of the patients indicated that they had not undertaken further help seeking for their disorder. Of the patients who indicated continued help seeking, 15% did so by visiting TCM doctors, 5% by visiting Western style medical doctors and 18% had used further self or family treatment. Thus, the majority of the depressed patients showed a favourable response to antidepressant treatment that translated into diminished help seeking.

However, in reply to the question about what they called their problem, 69% of these patients maintained that they suffered from neurasthenia, and only 11% said their disorder was 'depression' (21% applied different labels). Kleinman (1982) stated that

"there was only a 7% change in explanatory models from neurasthenia to depression not withstanding explanations to the contrary and positive response to treatment identified as specific for depression. ... Indeed most patients actively denied their disorder was depression when we tried to assert it was" (p. 165). Whether it was firmly entrenched illness beliefs or the stigma associated with a diagnosis of 'depression' or some other factor, these patients steadfastly maintained the belief that they suffered from neurasthenia.

Kleinman's (1982) results regarding high rates of utilisation of TCM in China stand in stark contrast to those of Cheung, Lau and Wong (1984) in Hong Kong (reported above). This reinforces the idea that popular acceptance and availability of such services of such services (in part determined by governmental policy) exerts a strong influence on help seeking and utilisation patterns. Kleinman's research sparked a heated debate in the psychiatric community both inside and outside China that continues today[13]. It brought into question the validity of neurasthenia as a diagnostic entity and, interestingly, has raised questions around the validity of the (primarily psychologically oriented) DSM diagnostic criteria for depression.

A closing observation is warranted here. Kleinman (1982) found a surprising paucity of suicidal ideation among the Hunan patients. He speculated that this could indicate that where depression is conceptualised as an organic illness (as in the depressed neurasthenics' cases) self-deprecation and guilt may be significantly minimised, with a concomitant diminution in the tendency to suicide. This is very similar to Marsella's

---

[13] During lectures I delivered and forums I participated in at Beijing Medical University, I had many spirited discussions with my students, practising psychiatrists and psychiatric interns on this topic. It seemed that they were almost equally split on the question of the nosological validity of neurasthenia, however, few questioned depression's value as a diagnostic category.

(1980) earlier argument that somatised depression may be more amenable to treatment in that it does not involve the existential elements that so complicate 'psychologised' depression. In any case, the work of these two pioneers of anthropological psychology and psychiatry has stimulated a healthy debate and a prolific research orientation around culture's impact on depression that will likely continue long into the future.

In this context it is important to reiterate that, at the present time, the Chinese suicide rate is considered to be among the highest in the world (Phillips, Liu, & Zhang, 1999). This suggests several important hypotheses in relation to Kleinman's (1982) findings. One possible hypothesis is that that there has been a fundamental shift overt the past few decades in the experience and expression of depression among Chinese from the 'somatic' to the 'psychologised' type and this has been accompanied by a dramatic increase in suicide. Similarly it may be possible that there has been an equally dramatic increase in the tendency among those with somatic symptoms to attempt suicide.

It is possible that in patients for whom somatic complaints are primary (and even indicative of underlying depression) there is a lower tendency to entertain thoughts about suicide and, therefore, in China suicide is less associated with depression or neurasthenia. Pearson (1995) gives voice to this perspective in her discussion of depression and suicide:

> *To assume that the high rate of suicide reflects an equally high rate of depression may not be entirely correct. Suicide is, of course, not only a gesture of despair but may also be one of anger and revenge. This is particularly likely among a group* [young, particularly female, rural Chinese] *who in other ways have so little control over their own lives, and little means of redress*

against the injustices they suffer. Many people believe that the unquiet spirit of a suicide will return to haunt the household and wreak its revenge, thus gaining power in the spiritual world that was not possible in the temporal one.

Similarly, Phillips, Liu and Zhang, (1999) argue that there is not necessarily a direct relationship between depression and the high rates of suicide in China. These authors suggest instead that there is a dynamic relationship between several interacting factors that has, as a combined effect, increased suicides in China. Along with high levels of untreated depression, Phillips, Liu and Zhang argue for the impact of cultural beliefs (such as those cited by Pearson above), economic and social changes occurring since 1978, the high availability of lethal means to suicide and the lack of suicide prevention services (e.g., suicide crisis lines). This would suggest that while depression alone is not entirely responsible for the high rates of suicide in China, it definitely plays a pivotal role.

A final possible explanation for the lack of reference to suicide among Kleinman's subjects, however, is that some these depressed/neurasthenic patients may have harboured, but did not (for whatever reason) reveal suicidal ideation. Cheung (1986b) discussed the differential presentation of symptoms (i.e., somatic versus psychological) as a function of setting and of the manner of investigation by the clinician. Those presenting in medical settings most often cited somatic complaints, however, gentle prodding could elicit psychological symptoms and existential angst. It is therefore possible that the manner of the investigation in the Kleinman studies failed to uncover suicidal ideation simply by not persistently asking the right questions. In any case, while

suicide did not seem to constitute a major threat among Kleinman's subjects in the early 1980s, it is undeniably a significant problem today.

In a re-analysis of Cheung, Lau and Wong's (1984) data, Fanny Cheung (1987) explored the interaction between patients' conceptualisations of their problems and their help seeking patterns. Patients' problem conceptualisations were categorised as purely psychological, purely somatic or mixed. Patients with a purely psychological conceptualisation of their disorder initially employed more self-help, principally in the form of psychological coping strategies. Patients with a purely somatic or mixed conceptualisation of their disorder initially relied on professional resources.

For patients who approached professional resources initially the overwhelming majority sought out Western medical resources (including MDs and general hospitals). However, those with purely psychological conceptualisations of their disorder where less likely to do so than those with somatic or mixed conceptualisations. On the other hand, the patients holding purely psychological conceptualisations were more likely than the members of the other two groups to initially approach mental health professionals as a first stop on the road to their current psychiatric consultation.

Cheung (1987) also examined the delay between problem onset and contact with various professional resources. Here she found that those with mixed conceptualisations sought professional help earliest, while the psychological group waited the longest and the purely somatic group was intermediate between these two. When the delay between problem onset and first contact with *mental health* professionals was examined, those with a mixed conceptualisation again arrived first, however, this time the purely somatic group took longer than the purely psychological group. An almost identical pattern of delays emerged when Cheung examined the time between problem onset and the

patient's current consultation at the private or the public psychiatric clinic (i.e., mixed had the shortest, psychological had intermediate delays and somatic had the longest delays).

When patients' conceptualisations were compared based on the type of resource[14] they had approached, an interesting picture emerged. Cheung (1987) found that almost equal proportions (43.8% and 45.8% respectively) of those who approached mental health professionals held purely psychological or mixed conceptualisations of their problems, while only a minority (10.4%) of these patients viewed their problems in strictly somatic terms. Of those patients who utilised TCM resources, the majority (54.5%) held mixed conceptualisations of their problems while 28.8% and 16.7% (respectively) held purely somatic or purely psychological conceptualisations. In terms of those who indicated that they had approached a folk religious source of help, again, the majority held mixed conceptualisations. Those who held purely somatic and purely psychological conceptualisations constituted 11.1% and 36.1% (respectively) of those seeking supernatural intervention. Thus, those with a mixed psychological and somatic view of their disorder were almost equally represented at each of these three sources of help. However, among TCM subscribers, more held somatic than psychological views of their disorder, while the reverse pattern held among utilisers of folk healing.

As mentioned earlier, it is important to remember that this was a very diverse group in terms of their diagnoses. The particular diagnosis and symptoms a patient is grappling with would conceivably have a significant impact on his or her problem conceptualisations and help seeking strategies. With that caveat in mind, a picture of the interaction of problem conceptualisation and help seeking patterns clearly emerged

[14] In this analysis Cheung excluded Western medical resources since nearly all of the patients sought this form of help.

from Cheung's (1987) analysis. As psychologists, in our attempts at public mental health education we may be tempted to invoke psychological explanations for many of the disorders faced by people with mental health problems. Conversely, those in the medical or psychiatric communities may be more disposed to apply a purely biomedical explanatory model to such difficulties. One implication of Cheung's findings is that promoting a more encompassing 'bio-psycho-social' model of mental health problems may be most helpful in facilitating more appropriate and effective help seeking by mental health service consumers.

In a study that comes perhaps closest to the current research in both approach and matter, Ying (1990) conducted structured interviews with recently immigrated Chinese women in the US to gauge the interaction between their explanatory models of depression and their perceptions of appropriate sources of help for the disorder. The participants in her study were recently immigrated Mainland Chinese women attending postnatal care for their children (i.e., not depressed patients seeking care for themselves). These women read a vignette depicting Mrs. Wong suffering from depression. They were then asked about the nature and help seeking alternatives appropriate for the problem.

Subjects were asked to provide a name for Mrs. Wong's problem, as a measure of their 'problem conceptualisation'. Responses categorised as 'psychological' were in the majority (57.5%) and included labels such as low or unstable mood, worry, nervousness/anxiety and psychiatric problem. 'Physiological' category responses were the less frequent (30%) and included such things as neurasthenia, physical illness, heart problem, having a cold and pregnancy (about 5% indicated they did not know what to call the problem). These categories were then used to contrast causal beliefs.

About one third of the 'psychological' group and over half of the 'physiological' group viewed external stress as the primary cause of Mrs. Wong's problem. The lowest proportions of both groups (9.5% of the psychological group, and 16.7% of the physiological group) held physical factors to be responsible for producing Mrs. Wong's condition.

With respect to problem conceptualisation's impact on help seeking, Ying's (1990) results were similar to those of Cheung (1987). Ying found that only a third of those subjects holding a psychological conceptualisation of the problem would recommend the Mrs. Wong seek professional help. The remainder of these subjects recommended that she rely on herself and/or family and friends to help her through her difficulties. By contrast, over seventy-five percent of subjects holding a physiological conceptualisation of Mrs. Wong's problem suggested professional help. Of those subjects who held a psychological conceptualisation of Mrs. Wong's problem and suggested professional help, 71.4% recommended she seek psychological help. Conversely, 77.8% of the physiological conceptualisation group that recommended professional help, suggested she see a Western MD.

It must be remembered that these were, ostensibly, non-depressed, non-patient subjects. In this regard it is valid to question whether their responses reflect what they would actually do if they themselves were grappling with depression. On the other hand, if their responses can be taken as reasonably accurate reflections of the impact of EMs on help seeking, then the implications are clear. More needs to be done in terms of the interface between primary care physicians and mental health professionals, and efforts at mental health education need to be targeted at newly arrived immigrants to make them aware of the services available and the efficacy of those services.

Taken together, these findings support the notion that culturally inculcated illness beliefs and beliefs about appropriate anti-depressive behaviour are significantly influenced by culture.

Critique of the Available Research Literature

Perhaps the most significant gap in the current literature on Chinese causal beliefs and help seeking preferences relates to the group studied. An extensive search of the literature turned up very few studies of causal beliefs and/or help seeking preferences or behaviours that were conducted in the People's Republic of China. There are, no doubt, similarities between the beliefs of Chinese acculturated in other places and those of Chinese from the People's Republic. However, to equate Chinese from all parts of the world in terms of their beliefs and preferences is to "dismiss the enormous historical and socio-political differences that exist between [the people of] these regions" (Blowers, 1996, p. 3). Chinese people living in the China of today inevitably have a different social and cultural experience than Chinese who have lived all, or significant proportions, of their lives outside of China. Similarly, there is a wide variation in the social and cultural experience of Chinese living in different milieus within China. Since the Chinese of the People's Republic of China constitute roughly one-fifth of the world's population, it is important that the health and worldviews of this group be more thoroughly understood.

A second major gap concerns the pathologies studied. Much of the previous research focussed on schizophrenia or other disorders with florid presentations (e.g., bipolar II disorder or Major Depression-psychotic type) that are most often treated in psychiatric hospitals. Since non-psychotic major depression is a more frequently occurring problem, the dearth of research addressing this problem constitutes a major shortcoming.

Another deficit in the literature is the way in which causal beliefs and help seeking preferences have been studied. The vast majority of studies have examined these variables in isolation. Only a minority (e.g., Cheung, 1987 and Ying, 1990, reviewed above) attempted to systematically measure and link these beliefs and preferences in the same study.

While much has been done in various discrete contexts, a comprehensive and encompassing examination is lacking. One of the difficulties is that research on beliefs and help seeking preferences has generally employed either clinical *or* non-clinical layperson samples but not both. Further, there is a paucity of research contrasting the causal beliefs of laypersons and health care professionals. As Cheung (1987) suggested, experience with various sectors of the healthcare system may have a significant impact on lay people's causal beliefs and help seeking preferences and/or strategies. Similarly, it is important to understand health care professional's causal models of depression and to compare these with those of laypersons.

A further gap in the current literature is an examination of the effect of level of depressive symptoms on causal beliefs and help seeking preferences. As mentioned earlier, causal beliefs may influence the choices that depressed individuals will make regarding appropriate sources of help. Similarly, causal beliefs will influence the advice that others give to the depressed individual about how to get over depression. Causal beliefs also influence how depressed individuals are viewed by themselves and by those around them. If the level of depressive symptoms being experienced by the principal sufferer has a significant effect on causal beliefs and help seeking preferences, this may result in very different causal perspectives being held by the ill individual and those around him or her. If the individual perceives the cause of his or her depression as beyond his or her control but those around him or her do not, this can lead to a loss of

social support. Social support has been shown to be important in minimising the impact of depression (e.g., Lin, & Ensel, 1984). Further, if the level of depressive symptoms significantly impacts causal beliefs and/or help seeking preferences, an understanding of this impact is crucial to effective delivery and implementation of care to depressed individuals.

Another difficulty that has been present all too often in the literature on depression is the ambiguity of the disorder being presented as 'depression'. Few studies have provided a clear and culturally relevant description or definition of depression for their subjects. This has led to questions about what is actually being measured (see criticisms of the Rippere studies reported above).

The Current Study's Contribution

The current research was designed to address many of these gaps in the literature:

- First, the study was conducted in China in order to measure causal beliefs and help seeking preferences within this culture as opposed to those of Chinese people in other geographical and socio-cultural milieus.

- Second, this study is concerned with major depressive disorder rather than some of the more florid and less frequently occurring psychopathologies.

- Third, the current research employed a less ambiguous and more culturally appropriate depiction of depression. This approach was intended to facilitate a clearer and more focussed understanding of causal beliefs and help seeking preferences for this specific disorder.

- Fourth, the current research used multiple sub-samples that were, both within and across groups, heterogeneous with respect to various independent variables such as gender, age, education, clinical status and level of depressive symptoms. These latter two variables were measured in a systematic way to allow contrasts with respect to the influence of each on causal beliefs and help seeking preferences.

- Fifth, and finally, the current study also measured the causal beliefs about depression held by an array of health care professionals in China, to allow a comparison of these beliefs with those of laypersons.

Chapter 3 - Methods

Introduction

The current research had three principal aims. The first aim was to define and compare Chinese lay and professional people's causal beliefs about depression. The second aim was to gauge Chinese lay people's help seeking preferences for the disorder. The third aim was to determine the impact of experience in the mental health system (clinical status) and of the severity of depressive symptoms on the causal beliefs and help seeking preferences of lay people. For several reasons a survey research design was deemed the most appropriate method to achieve these goals. First, given time and financial constraints, it was possible to reach greater numbers of subjects using a standardised questionnaire than by conducting face-to-face interviews. The second, concomitant, reason is that by reaching greater numbers of subjects one can enhance the heterogeneity of the sample, which, in turn, enhances the generalisability of the results. Finally, a survey design provided a degree of anonymity to the participants. Given the fact that subjects were being asked questions regarding the sensitive topic of 'mental health' (including their own), it was believed that the survey approach would minimise biasing effects such as social desirability.

This research combined qualitative and quantitative methods that were informed by a combination of etic and emic methods in both data gathering and interpretation. While there already exist several different forms of questionnaires that previous researchers have used to gauge causal beliefs about psychological problems, it was decided to utilise, as much as possible, locally derived items to enhance the validity of the questionnaires and the results derived thereby. Since no similar research had ever been conducted in

China there were no suitable questionnaires already available. While Luk, & Bond (1992) had constructed a causal attribution scale for use in Hong Kong, it was believed that cultural differences between Hong Kong and Beijing might limit the usefulness of some of their items. Therefore, the current study was conducted in two phases. In the first phase, focus groups were employed in order to elicit items that could be used to modify and expand the causal beliefs and help seeking preferences scales. In the second phase, the questionnaires were administered to the main research sub-samples. This chapter is devoted to providing a description of the development of the questionnaires including a discussion of such things as validity and reliability, a delineation of the methods used to conduct the research and a detailed description of the sample.

Instrumentation

Each questionnaire (see Appendices A & B) began with an introduction describing the purpose of the study, giving instructions for completing the questionnaire, assuring anonymity and confidentiality, and covering other ethical concerns such as informed consent, the right to terminate participation etc. Lay subjects were then asked to complete a brief questionnaire covering demographic information such as sex, age, level of education, etc. A two-part questionnaire followed this to evaluate causal beliefs and help seeking preferences. The first part consisted of a vignette[15] describing the condition

[15] The vignettes reflected both a 'Western' symptom pattern using core symptom of depression from the DSM-IV, and an 'Eastern' symptom pattern using somatic symptom described by Beard (1869; 1881) and Kleinman (1986) for Neurasthenia. This was done to compensate for differences in 'Western' and Chinese conceptualisations of depression as described by a number of authors (Fabrega, 1989; Marsella 1980; Kleinman, 1986). The vignettes were balanced for gender such that half of the questionnaires contained vignettes that depicted a female and half depicted a male displaying the symptoms. This was an attempt to test for the effect of stimulus gender on subjects' ratings. Subsequent analysis revealed that differences in the labelling of the disorder did arise as a function of the stimulus gender (more subjects given the female stimulus character indicated that the problem was 'depression' than did subjects receiving the male stimulus character). This finding will be explored in detail in a separate publication.

of and symptoms expressed by a hypothetical person suffering from 'depression'[16]. This was followed by a 26 item rating scale of possible causes and a 16 item help seeking preferences rating scale. Lay subjects were last administered the Chinese Depression Inventory (Zheng, & Lin, 1991).

As with the lay subjects, professional subjects were first asked to provide demographic information, however information was also elicited regarding professional factors such as years of professional education, years in professional practice etc. (see Appendices C and D). Professional subjects were then given the vignette and were also asked to provide a name for the problem depicted in the vignette. They then completed the same causal belief scale used in the lay questionnaire.

In the second half of the professional questionnaire subjects were asked open-ended questions to elicit information regarding such things as the number of patients they treated with problems similar to that depicted in the vignette, what they did to treat such patients, and other treatment related information. Because some clinicians may not have dealt directly with depressed patients, the questionnaire was arranged in an alternative response format. In this way, clinicians who had not treated depressed patients personally were asked to hypothesise about the treatment they would provide to such patients. The results of this part of the study will be reported in a separate publication.

[16] Subjects were not informed that the vignette describes 'depression'. Rather, they were asked to indicate what they believe the problem might be called.

Development of the Questionnaires

Development of the Vignette

The vignette used as the key stimulus in the research was developed using criteria for depression drawn from three sources. The first source was a vignette created by Ying (1990) to study Chinese immigrant women's explanatory models of, and help seeking for depression. The second source was the diagnostic criteria for Major Depressive Episode outlined in the DSM-IV (American Psychiatric Association, 1994). The third source was the cardinal symptom group for neurasthenia described by Beard (1869; 1881) and Kleinman (1986).

The initial vignette was presented to seven mental health professionals for review. These included two Canadian researchers, a psychologist and a psychiatrist, who are Chinese/English bilinguals and possess a combined total of over 40 years of experience conducting research in and about China. Two Chinese psychiatrists with 24 years of clinical experience collectively also reviewed the vignette. Three Chinese psychologists reviewing the vignette included one professor with 16 years of teaching experience in psychology at a leading Chinese university and two clinical psychologists with 12 years of clinical experience collectively.

These professionals were asked to review the vignette to judge whether it was an accurate depiction of depression among Chinese clinical populations. In cases where the reviewers were bilingual (five of the seven), they were asked to compare the vignettes for semantic equivalence between the Chinese and English versions. Several changes in Chinese wording, the deletion of two psychological symptoms (relating to guilt and libidinal functioning) and the addition of one somatic symptom (neck pain) resulted

from this process. Adjustments were made in the English translation to reflect the content of the Chinese version.

Development of the Causal Beliefs and Help Seeking Questionnaires

In creating the lay-beliefs and help seeking questionnaires, a combination etic and emic approach to scale development was deemed most appropriate. Previous research in lay beliefs about psychological problems had incorporated rating scales used in other settings (see for example: Furnham, & Henley, 1986; Henley, & Furnham, 1986; Luk, & Bond, 1992; Sinclair, 1994). In the latter two cases, this was done to allow cross-cultural comparisons of causal beliefs. However, the current scale was developed with the notion in mind that the lack of cultural equivalence in disease concepts (particularly with respect to psychological problems) may compromise the usefulness of some previously developed scale items in different cultures.

A decision was made, therefore, to build on and modify existing causal beliefs and help seeking preference scales by employing focus groups. As mentioned above, the three focus groups consisted of 10 Chinese volunteers per group. Groups were selected based on place of residence and general educational level (one rural group, one urban community group and one group consisting of university students and staff). Within groups, subjects were recruited based on age and gender. Attempts were made to balance the groups for gender and achieve as much variability in age as possible. In respect to this latter criterion an attempt was made to sample as wide a range of ages as possible, however, as is evident in the detailed sub-sample descriptions below, the age distribution was truncated in the case of the university student sample.

Conducting the Focus Groups

In each focus group, participants were given the vignette to read and asked to indicate:

1) the name of the problem

2) what might cause someone to suffer from such a problem

3) what sorts of help might be useful for someone to get over such a problem

In the first part of the focus group process (individual written response phase), each member was asked to write down, individually, any responses to these questions that came to mind. During the second part of the focus group process (whole-group verbal response phase), after recording the written responses on a large flip chart, all members were asked to discuss responses to each question and to "see if there were any additional items that may not have occurred to them individually". For each item generated through this process, members of the focus group were asked to endorse (by a show of hands) those items they felt were 'plausible' causes or help seeking resources.

In analysing the focus group responses, any response that was written or endorsed (by show of hands) by more than 50% of the members of any particular group was included in the respective scale. Because of the focus groups, several modifications were made to the two scales. The final version of the causal beliefs retained the original number of items (26). However, 10 of the items were replaced or modified to reflect the findings from the focus groups[17]. The final version of the help seeking preferences scale consisted

[17] It is noteworthy that many of the items from the source questionnaires were retained in either their original form or in slightly modified form while retaining the original concept. This suggests two very important ideas. First, it reinforces the validity of the items constituting the source questionnaires in assessing both of the constructs under study (i.e., causal beliefs and help seeking preferences). Second, it suggests a core of causal beliefs and help seeking

of 16 items. An open-ended response alternative was included at the bottom of each scale to elicit idiosyncratic responses.

The Final Form of the Lay Questionnaire

Causal Attribution Scale

The 26 cause attributions was administered to all subjects and include items ranging from 'The problem is caused by the person's genetic disposition' to 'The person is disturbed by supernatural forces'. Subjects were instructed to 'Please rate each of the items listed below as to how important you believe it is in causing someone to suffer from this problem' on a five-point Likert-type scale. The scale was anchored by 'This contributor is not important at all' (zero) and 'This is an extremely important contributor' (four).

The Help Seeking Preferences Scale

The second part of the questionnaire presented clinical and non-clinical lay subjects with 16 help seeking alternatives (acupuncturist, family member, psychiatrist, etc.). Lay subjects were asked to 'Please rate the items listed below as to how likely you would be to pursue each alternative if you were experiencing this type of problem'. Items on this inventory were also rated on a five-point Likert-type scale. This scale was anchored by 'I would not seek this form of help' (zero) to 'I would definitely seek this form of help' (four).

---

preferences that apparently transcend cultural boundaries in that the items constituting the source questionnaires were constructed and employed in the U.S., Britain, and Hong Kong.

The Chinese Depression Inventory

Lay subjects were also administered the Chinese Depression Inventory (Zheng, & Lin, 1991). The scale consists of 20 items consisting of Likert-type format involving five response choices for each item. The scale yields a single indicator score reflecting the current level of depressive symptoms of the subject.

Development of the Professional questionnaire

The Professional questionnaire was developed with the aid and guidance of Dr. Michael Phillips. Dr. Phillips is a fluently bilingual Canadian psychiatrist and professor who, at the time of this study, had lived and conducted research in China for more than 13 years. The questionnaire was structured with a view to eliciting two types of information; 1) the causal beliefs about depression held by Chinese health care professionals and, 2) information about their experience with depressed patients and their approach to the treatment of depression[18]. Wherever possible questions were open ended and phrased so as not to influence responses in any way.

Final Form of the Professional Questionnaire

The professional subjects received a variation of the demographic questionnaire that also requested information such as the nature of their training/degree, specialisation (if any), length of time in their occupation, etc. They also read the vignette and were then asked to name the problem. As with the lay subjects, professional subjects were asked to rate the causal attributions. Finally, they will be asked to describe in detail the procedure

---

[18] The current discussion is limited to the ratings of causal beliefs by the health care professionals. The other issues will be addressed in a separate publication.

they would use to treat/help a person with such a problem, and to provide reasons for their choice of treatments.

Validity

The literature reviewed earlier suggests that Chinese lay people hold different conceptualisations of the manifestations of depression from those held by their North American or British counterparts. Therefore, an attempt was made to enhance the overall validity of the current study by offering vignettes that describe a symptom pattern reflecting both the Western 'psychological' symptoms and some 'Eastern' (somatic) symptoms. This has the further advantage of presenting a more balanced (psychological versus vegetative) symptom picture with the intent that it created a minimal biasing influence on subjects' ratings of the causes of the disorder.

In terms of the causal attributions rating scale, Furnham and Henley (1988), and Luk and Bond (1992) modified the items derived from the Knapp and Karabenick (1985) questionnaire. They did this using additional attributions gathered through one-on-one interviews (with 6 British and 10 Chinese subjects, respectively), expanding the list of possible 'causal attributions' to 26. These procedures enhanced the external validity of the original 20-item questionnaire designed by Knapp and Karabenick (1985) producing a more exhaustive and, in the case of Luk and Bond (1992) a more culturally sensitive instrument for use with Chinese populations.

The current study further enhanced the validity of the causal attributions scale through a culturally appropriate translation by experienced bilingual Canadian and Chinese mental health professionals and by employing the focus groups described earlier. In a similar vein, the items that made up the help seeking preferences scale were emically

derived. Therefore, they should be a reasonably valid and comprehensive reflection the actual range of helping alternatives that is relevant in the current Chinese context. As a final procedure to strengthen the overall validity of the study, subjects were offered the option to provide any causal attributions or help seeking alternatives that were not already listed. However, very few subjects provided such responses.

The validity of the CDI was found to be very strong (Zheng, & Lin, 1991). As reported by Zheng and Lin, the original items in the CDI were derived from several sources. These included items from Chinese versions of other depression scales such as the Beck Depression Inventory, the Zung Self-report Depression Scale and the Hamilton Rating Scale for Depression. These authors also derived items from an earlier study of terms used by depressed patients to express depressive states (Zheng, Xu, & Shen, 1986). As is mentioned in the limitations section, however, the CDI has never been applied to non-clinical populations. Thus, its validity under the current research conditions (i.e., with clinical and non-clinical subjects) was not known a priori.

Reliability

Causal Beliefs and Help Seeking Scales

With respect to the causal beliefs scale, the original 20 items "were designed to tap the various dimensions of Weiner's (1980) attributional framework" (Knapp, & Karabenick, 1985, p. 384) regarding the causes of psychological problems. While reliability figures are not available for this instrument, replications and extensions using the same items (Furnham, & Henley, 1988; Henley, & Furnham, 1988; Knapp, & Karabenick, 1985) yielded strikingly similar factor structures. These factor structures emerged despite the fact that the studies involved different populations and that different psychological

problems were used as stimuli in all three studies. Therefore, the basic scale, as used in non-Chinese populations shows reasonable reliability in terms of the underlying factors. In contrast, the help seeking preferences scale used in the current study is essentially a new instrument; therefore, no comparable data were available for this scale a priori.

Ideally, a measure of test-retest reliability would have been desirable (Backstrom, & Hursh-César, 1981). However, the current scales were intentionally administered only once to each subject. Therefore, calculating test-retest reliabilities was not an option. It was considered that a second administration would not be valid for two reasons. First, as a matter of ethics, subjects were debriefed about the purpose of the study after completing the questionnaire, their responses on a subsequent administration would be biased by this knowledge. Second, it is likely (as was reported to the researcher by numerous subjects) that subjects became aware of the nature of the disorder under study because of completing the questionnaire. The current problem reflects a nearly universal difficulty in psychological measurement. It was perhaps best stated by Cronbach when he wrote, "Successive measurements of psychological quantities are rarely independent ... because the act of measurement may change the quantity [measured]" (1947, p.2). Thus, after the first administration of the questionnaires, subjects would no longer be naive to the study and this would likely bias their ratings on the second administration.

A second factor militates against calculating reliabilities for the current scales. Items within each scale were designed to measure divergent concepts within the two domains (causal beliefs and help seeking preferences). Thus, the heterogeneity of the scale content does not lend itself to measures of internal reliability such as Cronbach's Alpha (Guilford, & Fruchter, 1973). It will remain for future research to examine the reliability of these scales.

Chinese Depression Inventory

The Chinese Depression Inventory has been found to possess acceptable reliability. In their study of the CDI, Zhang and Lin (1991) compared it to a Chinese version of the Beck Depression Inventory (CBDI) with favourable results. Zheng and Lin reported Cronbach's alphas, of 0.91 for the CDI and 0.85 for the CBDI. In the current study the CDI scores yielded a Cronbach's Alpha of 0.93. The CDI was also evaluated using the split-half method. The split-half analysis yielded a correlation of 0.75 between forms. These results suggest that the CDI is a very reliable instrument for measuring depressive symptoms in Chinese populations.

Research Samples

In a sense, this was a convenience sample in that several factories, community, farming and seniors' groups, hospitals and universities agreed to participate in subject recruitment. In the formal sense, the sampling procedure used was cluster sampling. Clusters were designed to provide appropriately large and heterogeneous sub-samples[19] that differed on the major demographic and other independent variables under study, while at the same time keeping the sample collection within the realm of the possible given time and financial constraints[20].

With that caveat, within each sub-sample, the sampling technique used was random sampling. The major criteria for creating the sub-samples were level of education, place of residence (urban vs. rural) and clinical status. It happened that the sample was very similar to the general population on many dimensions. However, the primary intent

---

[19] In the remainder of the text, sample clusters will be referred to as 'sub-samples' since this more clearly captures the relationship between the overall sample and the clusters.

[20] The current research was entirely funded by the author.

was not to match the sample to the general population. The differences between the research sample characteristics and the relevant population parameters are discussed below.

Phase-one Sample: The Focus Groups

The author and two research assistants recruited volunteers in person to participate in three focus groups. The first group consisted of 10 students attending the university from which the main university sub-sample was drawn. The second group consisted of 10 members of the urban community from which the urban community sub-sample was drawn. The third group consisted of 10 rural migrant workers residing in the community from which the urban community sub-sample was drawn. The main criterion for selection was that the participants not be trained in any mental health speciality. Each participant was paid a 10 yuan (about $2.00 Canadian) honorarium and soft-drinks were served free of charge during the focus group sessions.

Phase-two Sample: The Main Research Sample

The main research sample consisted of three groups of Chinese participants. The three major subdivisions of the sample were comprised of non-clinical, clinical and professional subjects. The non-clinical sub-samples[21] were recruited from two districts in Beijing and one village approximately 130 kilometres northeast of Beijing. The clinical sub-sample consisted of inpatients and outpatients of the main Beijing psychiatric hospitals, and one general hospital offering outpatient psychological services in the Beijing region. The professional sub-sample consisted of clinicians at non-psychiatric

[21] Note: In the current context these groups of subjects are referred to as the urban-community sub-sample and the rural-community sub-sample. However, due to space limitations in tables presented below the urban-community sub-sample is referred to as the general sub-sample and the rural-community sub-sample is referred to simply as the rural sub-sample.

general medical hospitals, psychiatric hospitals, psychological counselling facilities and members of the Beijing psychologists association. Participants in the main study were paid a 5 yuan (about $1.00 Canadian) honorarium prior to completing the questionnaires. Subjects were informed that they could keep the honorarium regardless of whether they completed the entire questionnaire.

Sample Size

There were two criteria for selecting the sample size. The first criterion was the sample size recommendations of Comrey and Lee (1992). As a general rule of thumb for factor analysis, they suggested that 500 subjects constituted a 'good' sample. The second criterion was the power calculations by Cohen (1992) to provide a power of 0.80 to detect a medium (f = 0.25) effect size in one-way ANOVA. The optimal sub-sample size thus determined was approximately 150 subjects per sub-sample. This allowed for analyses in which subjects were grouped along the lines of variables such as age, education, income, locale of residence, etc. within sub-samples[22].

Subject Recruitment

General Comments

In all sub-samples return rates were high, ranging from 51% to 100%. As with all survey research, questionnaires were given to subjects but not returned. It is likely that these subjects decided to withdraw from the study or encountered some difficulty returning the completed questionnaire on time. In some instances, examination during data entry revealed that some respondents failed to complete whole sections of the questionnaire.

---

[22] Results of the ANOVAs using these variables will be reported in separate publications.

These questionnaires were retained but the data from them was not entered into the database.

University Sub-sample Recruitment

For the university sample, advertisements were posted outside campus dining halls where the majority of students and staff take their meals. The posters indicated the times and location (in the philosophy building, which was also the temporary home of the psychology department) for questionnaire distribution and collection. Questionnaires were distributed and collected over a three-day period from July 5th to July 7th from 9:00 AM to 9:00 PM. One hundred sixty questionnaires were distributed and all were returned completed.

Urban-community Sub-sample Recruitment

The urban-community sub-sample was recruited through a combination of poster advertisements and circulars. Advertisements were posted in well-travelled locations throughout each community and volunteers in their respective areas (i.e., the factory floor, the seniors' association, etc.) distributed circulars requesting participants. Four questionnaire distribution and collection points were established in the two communities (in 'storefront' locations along the main streets). Volunteers also solicited the participation of patrons visiting these locations over a three-day period from June 10th to June 12th, 1997 from 7:00 AM to 8:00 PM. Two hundred questionnaires were distributed in this manner, with 102 questionnaires being completed and returned.

Ten volunteers distributed questionnaires to randomly selected households of one of the factory dormitories. At the time of data collection, the dormitory consisted of 35 six-storey apartment blocks primarily housing factory workers and their families. Each

block consists of an average of 40 to 50 apartments. Each apartment was assigned a number and using a random number table to determine the first apartment to be canvassed. Residents at every 8th apartment were then offered the questionnaire if they met the criteria for the lay sample. Two hundred questionnaires were distributed in this manner with 158 questionnaires being completed and returned.

Rural-community Sub-sample Recruitment

For the rural sample, the data collection point was the Diao Ling village community hall. Three volunteers distributed and collected the questionnaires in the community. An attempt was made to contact all households in this village of about 800 people. Questionnaires were distributed and collected over a three-day period from July 25th to July 27th, 1997 from 8:00 AM to 7:00 PM. Two hundred questionnaires were distributed with 160 being completed and returned.

Clinical Sub-sample Recruitment

The clinical lay sample was collected through direct solicitation of patients by psychiatrists and clinical psychologists who volunteered to participate in the data collection. These clinicians were instructed to solicit the participation of patients who met the diagnostic criteria for depression only (i.e., patients with dual or ambiguous diagnoses, were excluded). The sample was collected at four hospitals. These included An Ding psychiatric hospital, Bei Yi (Beijing No. 6 hospital, the teaching hospital of Beijing Medical University) hospital psychiatric unit, Hui Long Guan psychiatric hospital, Zhong Ri general hospital psychology unit. Of 160 questionnaires distributed, between June 10th and August 18th, 1997, 143 were competed and returned.

Professional Sub-sample Recruitment

The professional sample was recruited from among the staff of the hospitals listed for the clinical sub-sample and from the Hai Dian district general hospital, the Hui Long Guan county general hospital and the Dao Ling county health services. In the case of the professional sample, participating practitioners in each setting were requested to circulate the questionnaire among colleagues who were ignorant of the study's purpose. Questionnaires were distributed and collected over a one-month period from August 08th to September 10th, 1997. One hundred sixty questionnaires were distributed with 100 completed and returned.

Description of the Overall Lay Sample

Gender

Table 1 shows the distribution of lay subjects by gender[23]. The distribution in the population by the 1990 census was male 50.9% and female 49.1% (State Statistical Bureau of the People's Republic of China, 1996)[24]. Therefore, it was believed that the sampling procedure was successful in attaining a reasonably representative sample with respect to gender.

---

[23] For some tables that follow the total sample size reported is less than the actual total sample size. This is due to the fact that some subjects left the answer fields of some of the demographic questions blank and, thus, information for those subjects is not available. The numbers of such individuals are reflected as the value labelled 'missing' in the affected tables.

[24] For the remainder of the discussion when population statistics for China are provided they are all drawn from this census report.

Table 1: Frequency distribution of lay subjects by gender

Subject Gender	n	Percent	Valid Percent	Cumulative Percent
Male	327	48.4	48.4	48.4
Female	348	51.5	51.6	100.0
Total	675	99.9	100.0	
Missing	1	.1		
Total	676	100.0		

Age

Table 2 shows the distribution of subjects in the sample by age groups. It is evident that there is a significantly greater proportion of younger people in the sample than that in the general population where 15 to 24 year olds constitute 22.26% of the population. This was because a separate university sample was included. These subjects were primarily undergraduate students and therefore younger aged individuals were over-represented.

Table 2: Frequency distribution of lay subjects by Age category

Age Category	n	Percent	Valid Percent	Cumulative Percent
15-24 years	228	33.7	33.9	33.9
25-34 years	168	24.9	25.0	58.9
35-44 years	122	18.0	18.2	77.1
45-54 years	87	12.9	12.9	90.0
55-64 years	39	5.8	5.8	95.8
65-74 years	21	3.1	3.1	99.0
75-80 years	7	1.0	1.0	100.0
Total	672	99.4	100.0	
Missing	4	.6		
Total	676	100.0		

The middle three age groups (i.e., from ages 25 to 54 years) are within approximately one percent of their actual population proportions. The actual population proportions for 55-64, 65-74 and 75-80 age groups are 10.11%, 6.48% and 1.59% (respectively). Thus, these latter three age categories are represented in the current sample by approximately half their respective proportions in the Chinese population.

Educational Attainment

As is evident from Table 3, the lay sample is also not representative of the educational distributions found in the general population. This, again, is due to inclusion of a separate university sub-sample. When this sub-sample is removed from the total non-clinical lay sub-sample, the distribution of educational categories more closely approximates that in the overall population distribution. The census data indicate that the distribution individuals with primary-, middle-, secondary school and post-secondary levels of education in the population is 24.83%, 36.80%, 23.81% and 15.37% (respectively).

Table 3: Frequency distribution of lay subjects by Educational category

Educational Category	n	Percent	Valid Percent	Cumulative Percent
Primary School	65	9.6	9.8	9.8
Middle School	158	23.4	23.8	33.6
High School	202	29.9	30.4	64.0
University	181	26.8	27.3	91.3
Grad. Degree	58	8.6	8.7	100.0
Total	664	98.2	100.0	
Missing	12	1.8		
Total	676	100.0		

Persons per Household

Up to the time of this writing, a search of the available census data failed to locate statistics showing a detailed analysis on a district level of the percentages of households by number of persons . Therefore, it was not possible to determine how representative (at a district level) the sample was with respect to this statistic. The 1990 national census indicated that the average number of residents per household in China was 3.70 persons. The same figure for Beijing was 3.1 persons. The mean number of persons per household in the current sample was 3.75.

Table 4 shows the percentages of subjects indicating the given numbers of persons residing in their home. It is evident that the number of 3 and 4 person households dominated in this sample. This likely reflects the one-child-per-family policy in force in China. It may reasonably be expected that the vast majority of the 3 person homes consisted of two parents and one child. It is likely that the number of 4 person homes also included a member of the extended family (i.e., a member of the grandparental generation). It can be reasonably assumed therefore that in the average urban household there were likely two wage earning adults.

Table 4: Frequency distribution of lay subjects by number of persons in household

Number in household	n	Percent	Valid Percent	Cumulative Percent
1	19	2.8	2.8	2.8
2	48	7.1	7.1	10.0
3	249	36.8	37.1	47.0
4	214	31.7	31.8	78.9
5	99	14.6	14.7	93.6
6	28	4.1	4.2	97.8
7	2	.3	.3	98.1
8	6	.9	.9	99.0
9	2	.3	.3	99.3
10	4	.6	.6	99.9
18	1	.1	.1	100.0
Total	672	99.4	100.0	
Missing	4	.6		
Total	676	100.0		

In the rural sub-sample, the majority of subjects (60.6%) reported four or more people per residence. By contrast, 70.0% of the university sub-sample, 86.2% of the general community sub-sample and 78.3% of the clinical sub-sample reported four or fewer persons residing in their homes. It is possible that some of the individuals reporting significantly high numbers (e.g., >7) of individuals in their household, may have misinterpreted the question and reported the number of persons in their family (i.e., the number of persons in their immediate family rather than the number residing in their home). However, some Chinese families also have family run businesses (e.g., restaurants) in which all family members, immediate and extended, may dwell under the same roof. Since the number of such respondents was small by comparison with the overall sample, this was not considered as constituting a significant biasing factor.

Income

Income categories were constructed by dividing the reported total monthly household income by the number of individuals per household (an approach recommended by Michael Phillips, personal communication, February, 1997). At the time of the study the income for urban workers was approximately 800 to 1,000 yuan per month. Since the majority of households in urban Beijing consist of dual income couples with one child, it was decided to set an arbitrary level of income per person in the household at 301 to 500 yuan. This is to say, an average family of 3 should have a total monthly income of about 900 to 1500 yuan. As is evident from Table 5 somewhat over three quarters of the sample reported incomes at or below this middle-income level.

Table 5: Frequency distribution of lay subjects by income category

Income category	n	Percent	Valid Percent	Cumulative Percent
Low (0-150)	133	19.7	20.6	20.6
Lower-Middle (151-300)	157	23.2	24.3	45.0
Middle (301-500)	203	30.0	31.5	76.4
Upper-middle (501-700)	64	9.5	9.9	86.4
High (701-900)	32	4.7	5.0	91.3
Affluent (>901)	56	8.3	8.7	100.0
Total	645	95.4	100.0	
Missing	31	4.6		
Total	676	100.0		

Marital Status

Table 6 reveals the marital statuses reported by subjects. Again, the inclusion of the university sub-sample biased this distribution. The 1995 national statistics indicated that 20% of adult Chinese citizens were never married, and 73.22% were married (including first married and re-married). There was no statistic available showing the proportion of individuals separated. The reported proportion for divorced people is 0.71% and

widowed people accounted for 6.07% of the population. Removing the influence of the university sub-sample only altered the percentages of single to married people in the sample to 27.3% versus 64.8% (respectively). Thus, after accounting for this influence the remaining lay sample is still slightly biased in favour of single individuals.

Table 6: Frequency distribution of lay subjects by Marital Status

Marital Status	n	Percent	Valid Percent	Cumulative Percent
single	284	42.0	42.2	42.2
married	347	51.3	51.6	93.8
separated	14	2.1	2.1	95.8
divorced	20	3.0	3.0	98.8
other	8	1.2	1.2	100.0
Total	673	99.6	100.0	
Missing	3	.4		
Total	676	100.0		

Locale of Birth

As Table 7 shows, the total lay sample was not consistent with the rural to urban population distribution in China (approximately 70% to 30% respectively) that existed at the time of the study. Since there has been a significant migration from rural to urban areas, many of these new residents being migrant workers, the urban community sample was designed to account for this.

Table 7: Frequency distribution of lay subjects by Locale of Birth

Locale of Birth	n	Percent	Valid Percent	Cumulative Percent
urban	342	50.6	50.7	50.7
rural	332	49.1	49.3	100.0
Total	674	99.7	100.0	
Missing	2	.3		
Total	676	100.0		

As noted in the detailed sub-sample descriptions below, the urban community sub-sample included 100 subjects (40.2%) who indicated a rural place of birth. The rural community sub-sample consisted of 142 subjects (95.9%) indicating a rural place of birth. Taking these two (urban and rural) sub-samples together, the urban to rural distribution in the overall sample of lay people becomes approximately 155 to 242 (39% to 61%). This distribution more closely approximates the actual urban versus rural population proportions.

Region of Birth

The distinction between 'northerner' and 'southerner' is somewhat arbitrary. It is arbitrary in the sense that there is no formalised way to measure this characteristic unequivocally. As such, there are no census data available that divide the Chinese population along north/south lines. However, the distinction is quite clear in the minds of the Chinese people. The Chinese often view themselves in terms of this dichotomy, which is conceptualised in terms of the character of the respective regions. Depending on whom you ask, northerners are characterised as being formal, bureaucratic, academic, artistic etc., while southerners are characterised as being informal, materialistic, traditional (read: superstitious), pragmatic etc. Since this dichotomy is such a salient aspect of self-definition among Chinese people, the decision was made to include it as a variable on the questionnaire.

Table 8: Frequency distribution of lay subjects by Region of Birth

Region of Birth	n	Percent	Valid Percent	Cumulative Percent
northern	553	81.8	82.0	82.0
southern	121	17.9	18.0	100.0
Total	674	99.7	100.0	
Missing	2	.3		
Total	676	100.0		

Detailed Description of the Sub-samples

University Sub-sample

This sub-sample was recruited at Beijing University, one of China's main university campuses. The university is a general post-secondary institution, offering undergraduate through advanced degrees in arts and sciences. Beijing University admits students from all parts of China. Therefore, this population is relatively heterogeneous with respect to students' regional origins and academic disciplines.

The university group (n = 150, 10 questionnaires were rejected) consisted of 82 (54.7%) males and 68 (45.3%) females. Their mean age was 22.41 years with a range of 18 to 36 years. Their mean level of education was 14.99 years with a range from 10 to 23 years. There was an average of 4.1 persons in the university households (range 1 to 8). Their average monthly household income was 1586.83 yuan[25] with a range of 12.00 to 7000.00 Yuan (4 failed to report income). The distribution of reported marital status was: 141 (94%) single, 8 (5.3%) married (including first and subsequent marriages), and 1 (.7%) was divorced (none reported separated or widowed status). Eighty-nine (59.3%) students reported that they were from northern China and 61 (40.7%) reported southern origins.

[25] The conversion ratio at the time of writing was about 5 Chinese yuan to 1 Canadian dollar.

There were 88 (58.7%) urban-born students and 62 (41.3%) reported they were born in rural areas.

Urban-Community Sub-sample

The urban-community sub-sample was drawn from the Qing He (pronounced 'ching herh') and Xi San Qi (pronounced 'see san chee') districts of Beijing. A wide range of people of varying socio-economic statuses populates both of these adjacent communities. The primary employer in Qing He is a relatively large and prosperous textile mill. Xi San Qi is dotted with many different factories that include small private firms, some larger state-owned enterprises and joint-venture companies. Employment, therefore, in these two districts is relatively stable, and the communities may be considered as relatively representative of China's working middle-class. In addition, both communities attract a wide variety of commuters and migrant workers who do contract work on such things as infrastructure and who operate a thriving service industry in the community markets.

The urban-community group (n = 249, 12 protocols were rejected) consisted of 105 (42.2%) males and 143 (57.4%) females (1 subject did not report gender). Their mean age was 37.16 years with a range of 15 to 79 years (3 failed to report age). Their mean level of education was 10.70 years with a range from 0 to 20 years (3 failed to report education). There was an average of 3.5 people in each of the urban households (3 failing to report) and their average monthly household income was 1863.18 yuan, with a range of 150.00 to 20,000.00 Yuan (4 failed to report income). The marital statuses were reported as: 66 (26.5%) single, 169 (67.9%) married, 7 (2.8%) reported they were separated and 4 (1.6%) were divorced and 2 reported 'other' (widowed) (1 person failed to report marital status). Two hundred eight (83.5%) reported that they were from

northern China and 41 (16.5%) reported southern origins. There were 148 (59.4%) urban-born respondents and 100 (40.2%) reported they were born in rural areas (1 person failed to report in this category).

Rural-Community Sub-sample

Dao Ling village, north-east of Beijing, is a small rural hamlet of about 800 people. Its economy is primarily agrarian with some light industry. The people of this community do not consider themselves particularly poor and told the research assistants that to see poor people "go back and see the people who live in the hills, at least we have clothes to wear all the time". On the other hand, many of the people saw themselves as economically disadvantaged by comparison with their urban counterparts. Many of the older residents decried the prevailing situation that saw most of the younger and better educated among them moving to the city. While there seemed to be a core of long-term well-established families, as with many small villages (particularly those located near larger cities), Dao Ling is a community in flux.

The rural-community group (n = 148, 12 protocols were rejected) consisted of 71 (48.0%) males and 77 (52.0%) females. Their mean age was 37.68 years with a range of 15 to 77 years. Their mean level of education was 7.74 years with a range from 0 to 13 years (3 failed to report education status). There was an average of 3.88 persons per household (1 failed to report the number of persons in the household) with an average monthly household income was 719.17 yuan, with a range of 0 to 3000.00 Yuan (3 failed to report income). The reported marital statuses were 37 (25.0%) single, 97 (65.5%) married, and 2 (1.4%) were separated, 6 (4.1%) reported being divorced and 5 (3.4%) reported 'other' status (widowed) (1 respondent failed to report marital status). One hundred forty three (96.6%) rural respondents reported that they were from northern China and 5 (3.4%)

reported southern origins. There were 142 (95.9%) reporting rural birthplace and there were 6 (4.1%) who reported they were born in urban areas.

Clinical Sub-sample

As mentioned above, the clinical sample was recruited from the inpatient and outpatient population of several psychiatric and one general hospital in Beijing. Because of the extended length of stay for those patients with comprehensive medical benefits, this was a relatively heterogeneous sample. For those who can afford it, inpatient treatment is often provided until patients have fully recovered. Therefore, there was a significant range in the severity of depressive symptoms reported by this group using the CDI.

The clinical sample consisted of 129 (14 of the 143 protocols received were rejected) inpatients and outpatients diagnosed with major depression. Clinical subjects included 69 (53.5%) males and 60 (46.5%) females. Their mean age was 37.87 years with a range of 16 to 66 years (1 failed to report age). Their mean level of education was 12.02 years with a range from 0 to 21 years (4 failed to report education). Their average monthly household income was 1561.97 yuan, with a range of 0.00 to 5000.00 Yuan (9 failed to report income). The analysis of reported marital status revealed 40 (31%) single, 73 (56.6%) married, 5 (3.9%) separated, 9 (7.0%) divorced and 1 (0.8%) reported 'other' status (widowed). One subject failed to report marital status. One hundred thirteen (87.6%) of the clinical subjects reported that they were from northern China and 14 (10.9%) reported southern origins (one failed to report in this category). One hundred (77.5%) clinical subjects reported being urban-born and 28 (21.7%) reported they were born in rural locales (again, one subject failed to provide this information).

Professional Sub-sample

The professional sample was recruited from among the staff of 6 hospitals and 4 university clinics, as well as from a rural setting just outside Beijing. The psychiatric hospitals included Beijing number 6 hospital (part of Beijing Medical University), An-Ding psychiatric hospital, and Hui Long Guan psychiatric hospital. The general hospitals included the Chinese-Japanese Friendship hospital, Guang An Men Traditional Chinese Medical hospital (housing the institute for research on TCM), Hui Long Guan community hospital. Members of the Beijing Clinical Psychologists Society also participated.

The sample consisted of 98 individuals (two protocols of 100 were rejected) representing 8 areas of specialisation. These included 38 general Western medical practitioners (these included 5 barefoot doctors who classified themselves as Western medical doctors), 15 Traditional Chinese medical practitioners, 2 nurses, 2 acupuncturists, 2 massage therapists, 24 psychiatrists and 10 psychologists. There were 40 males and 58 females. The mean age of the professional sample was 34.7 years with a range from 20 to 62 years. The mean educational level was 15.6 years with a range from 8 to 23 years. The professional sample reported an average of 4.66 years of professional education with a range from 1 to 11 years. These subjects reported an average of 10.13 years of professional practice with a range from 0 to 39 years. The mean of their total household monthly incomes was 2012.50 yuan with a range from 400 to 8000 yuan. There was an average of 3.34 people residing in the professional households with a range from 1 to 7 people. Their reported marital statuses were 27 single, 70 married and 1 divorced. There were 33 rural born and the remaining 65 were urban born. Northern-born professionals were in the majority at 85 with the remaining 13 reporting southern roots.

Data Collection

Brief screening interviews were conducted to ensure that participants met the inclusion criteria for their particular sub-sample. For the non-clinical sub-samples (the urban-community, rural-community and university sub-samples), the participation of one adult member (over 18 yrs.) of any given household was solicited. They were asked about the nature of their occupation and the highest level of education they had achieved. People with occupations or education related to mental health were excluded. Clinical subjects were selected based on diagnosis given by staff psychiatrists or psychologists at each facility.

After securing non-clinical lay subjects' agreement to participate, they were given the questionnaire in a plain envelope. Non-clinical subjects with a sufficiently high reading level were given the written package and the option to complete the questionnaire at the distribution site or at home[26]. In the cases where the questionnaires were delivered to the subject's home they were asked to complete the questionnaire within 48hrs and to drop it off at the collection site in their respective communities or the volunteer would offer to return and collect the questionnaire from their home. For low literacy, non-

---

[26] Individuals with fewer than 7 years of formal education were offered the option of having the volunteer work with them to complete the questionnaire. In such cases, the volunteers were instructed to read the questionnaire items verbatim and to use the literal Likert scale alternatives rather than just the numbers when they read each response alternative. In the university sample, as expected, there were no low literacy subjects. Subjects with fewer than 7 years of formal education constituted 7.2% of the urban community sample, 29.1% of the rural community sample and 3.2% of the clinical sample. The exact number of individuals requesting and receiving assistance with the questionnaire was not recorded. However, it may be expected that it was proportional to the numbers of low literacy people in each group.

clinical subjects the researchers administered the questionnaire in person at a time and place convenient for the subject and collected questionnaires after completion.

University participants were allowed to complete the questionnaires in a large room provided at the university for the purpose of data collection or to complete the form at home and return it the next day to the data collection room. At each of the urban community 'street-corner' distribution sites a table set up at which the subjects could complete the questionnaire in private (i.e., tables were situated such that subjects could not be observed by the public while completing the questionnaire). At the rural community site, subjects were offered the questionnaire to complete at home or at the community hall. These questionnaires were collected after completion at the community hall or returned to the community hall after completion at the subject's home.

Clinicians in each clinical setting administered the test materials. As mentioned earlier, these clinicians were instructed to include only subjects who met the research criteria for an exclusive diagnosis of Major Depressive Disorder (see definitions of terms). Due to the very limited number of individuals 'exclusively' diagnosed with depression, clinicians were asked to solicit the participation of all individuals in their respective facilities that met this criterion. They were provided with blank copies of the research instruments, and asked to collect the questionnaires upon completion. Where possible, clinicians were to arrange for subjects to complete the questionnaire privately.

For the professional sample, participating clinicians delivered the professional questionnaires to colleagues agreeing to participate. The professional subjects were also requested to complete the questionnaire within 48 hours and to return them to the individual who gave it to them.

Treatment of the Data

In addition to visually screening out incomplete questionnaires (i.e., questionnaires within which one or more entire scales were left blank), to further minimise the effect of response bias, only questionnaires on which the numeric sum of the ratings on each scale was equal to, or exceeded 5 for any given subject were included in each analysis[27]. In the initial analysis, the means and standard deviations were calculated for the ratings by the total sample of each of the causal attributions and each of the help seeking alternatives. These are presented in tabular form for visual inspection.

Subjects' ratings on the causal attribution scale and the help seeking preferences scale were then factor analysed[28]. The procedure consisted of Principal Components analysis with Varimax rotation using SPSS (version 8.02) for MS Windows. The number of factors to retain was based on the Scree test (Cattell, 1966, cited in Rummel, 1970), Components with Eigenvalues greater than 1.0 were retained.

Next, for each lay subject, a 'Factor Score' was calculated. This was accomplished by summing scores for items on which the given factor showed significant loadings (i.e., a factor loading greater than 0.4). This sum was then divided by the number of items used. The result was a score for each subject on each of the rotated components of the causal-belief and the help seeking preference scales that were derived during the factor analysis. Means and standard deviations of the 'Causal beliefs Factor' scores and the 'Help-seeking Factor' scores were examined as a gauge of endorsement for the respective

---

[27] It was felt that such response patterns would be invalid since this would indicate that the respondent rated none of the alternatives as important or only a one or two as marginally important. Where this was the case, particular attention was paid to the open-ended response options offered at the end of both the causal attribution scale and the help seeking preference scale. The results of these idiosyncratic responses will be reported in a separate publication.

[28] The factor analysis of the CDI was used primarily as a measure of internal validity. The detailed results of the CDI analysis will be reported in a separate publication.

factors. The factor scores were entered into a correlation[29] matrix using SPSS to examine the relationship between causal beliefs and help seeking preferences.

Each subject was next given a 'severity of depression' score based on the level of reported symptoms using the Chinese Depression Inventory. Using this procedure, each subject was placed into a discrete category defined by the classification system recommended by Zheng and Lin (1991). This system classifies individuals with CDI scores of 0 to 25 as 'normal'. Those with scores of 26 to 35 are considered to suffer from 'mild' depression. Those with scores between 36 and 45 are classified as 'moderately' depressed. Finally, those with scores of 46 and above are considered 'severely' depressed. Spearman's rank order correlations were calculated between severity of depression and Causal Factor scores, and between severity of depression and Help-seeking Factor scores as measures of association.

Finally, subjects were divided into categories based on clinical status. This was based simply on sub-sample membership (i.e., all non-clinical subjects compared to members of the clinical sample). This procedure allowed for comparisons of causal attributions and help seeking preferences based on experience in the mental health system.

---

[29] Stem and leaf plots were examined for normality of the individual Factor score distributions and scatter plots were examined for linearity between Cause and Help Seeking Factor scores. Several of these plots revealed non-normal distributions, and non-linearity between Cause Factors and Help Seeking Factors. Therefore, it was decided to use Spearman's rho to calculate correlation coefficients since this statistic is somewhat more robust in the face of such departures from normalcy and does not necessarily assume linearity of relationship between variables.

Chapter 4 - Results

The metric used to conduct many of the analyses was the Factor scores. Because of this and since factor analysis constituted the conceptual model for interpreting the underlying constructs, the results of the factor analyses are presented along with the descriptive statistics in each sub-section below.

Question #1: Which attributions do Chinese lay people and professionals rate as important causes of depression?

Lay People's Ratings of Causal Attributions

Descriptive statistics for causal attributions scale

Table 9 shows the means and standard deviations of the lay subjects' ratings on the causal attribution scale. The rating scale had a range of possible values from 0 to 4 ('zero' meaning the given attribution was not at all an important cause, and 'four' meaning the given attribution was definitely an important cause). The natural midpoint of the scale was a value of 2.0[30]. Thus, as a heuristic, those attributions receiving a mean rating of 2 or greater were interpreted as 'important' causes of depression. Attributions with mean ratings between 1 and 2 were considered 'moderately' important and those with mean ratings below 1 were considered as 'unimportant'[31] in the aetiology of depression.

---

[30] An examination of the grand means and standard deviations was conducted. The grand mean for the causal attribution ratings was 1.51 and the same figure for the help seeking alternatives was 1.49. The mean standard deviation for the causal attribution ratings was 0.59 and that for the help seeking alternatives was 0.78. Therefore, the current sample may have been slightly conservative in their ratings given these calculations. However, for the sake of simplicity the classification scheme noted above was adopted and seemed a reasonable and valid approach to interpreting the results.

[31] This heuristic was used with both the causal attributions and the help seeking alternatives.

Table 9: Means and standard deviations of lay peoples' ratings of causal attributions

Causal Attribution	Mean	Std. Deviation
Genetic predisposition	.71	1.08
Too educated or affluent	1.40	1.35
Low status vs expectations	2.42	1.37
Due to menopause	1.81	1.39
Lost someone close	2.09	1.45
Unlucky or predestined	.88	1.27
Too many defeats in life	2.04	1.25
Brain or nervous sys. problem	1.38	1.39
Too poor & unsatisfied with life	1.57	1.32
Lacks IQ or coping ability	.82	1.17
Problem in past (upbringing)	1.31	1.25
Neg. influence by media	1.02	1.12
Influenced by depressed others	1.14	1.18
Marital problems	2.19	1.37
Work/study environ. not good	1.68	1.24
Overworked	2.08	1.34
Poor health or low resistance	1.64	1.37
Supernatural beings	.54	1.06
Discordant fam. life	2.08	1.30
Discord co-workers or friends	2.02	1.29
Lacks willpower, too soft	2.08	1.48
Bad living environment	1.12	1.18
Infected by bacteria or germs	.66	1.10
Lacks formal education	.68	1.10
Lifestyle odd or different	1.11	1.13
Lacks spiritual beliefs	2.82	1.36

Table 9 reveals that nine attributions were endorsed as important causes of depression. The four highest rated causes were; 1) the individual lacks spiritual beliefs, 2) the individual has low status in life versus his/her expectations, 3) the individual is experiencing marital problems, and 4) the individual has lost someone close.

Three causes were tied for the fifth place position. These attributions were; 1) the individual lacks willpower (is too soft), 2) the individual is overworked, and 3) the individual is experiencing a discordant family life. The last two attributions rated as important causes of depression were; 1) the individual has experienced too many defeats

in life, and 2) the individual is experiencing discord with co-workers or friends. The lowest ratings were given to attributions such as the problem is caused by supernatural beings, the individual is infected by bacteria or germs, and the individual lacks formal education.

Factor analysis of causal attributions ratings

Table 10 shows the results of the Principal Components analysis of the causal attributions using Varimax rotation. This analysis resulted in a clearly interpretable seven-factor solution. Overall, the seven factors accounted for 53.02% of the variance.

The first factor, which accounted for 20.83%[32] of the variance, was labelled 'Biological - Fatalistic . This factor showed significant loadings on items that were primarily biological or mystical, but were all ostensibly beyond the individual's control. These included items such as; 'lacks IQ or coping ability', 'influenced by supernatural beings', 'genetic predisposition' and 'brain or nervous system problem'. Interestingly, two other factors also showed significant loadings on these latter two items. Factor six also loaded significantly on 'genetic predisposition'. Factor 7 loaded significantly on the item 'brain or nervous system problem'. Because these causal attributions displayed stronger loadings with, and were conceptually closer to the overall theme of the Biological – fatalistic factor, their weights were included in the calculation of the scores for this Causal Factor.

The second factor was labelled 'Environmental Stress - Downtrodden' and accounted for 8.15% of the total variance. This factor showed significant loadings on items including causes such as 'overwork', 'working or studying in a bad environment', and

having experienced 'many defeats in life'. This factor included the only other 'double loading' item in the analysis. Both factor 2 and factor 4 loaded significantly on item 20, 'discord with co-workers or friends'. It's higher loading with factor 2 may have been due to the fact that the item included the term 'co-workers' which may have led subjects to associate it with the words 'overwork' and 'working in a bad environment' both of which imply work-related difficulties.

Table 10: Rotated component matrix of Lay peoples' ratings of Causal Attributions

	Component						
Causal Attribution	1	2	3	4	5	6	7
Lacks IQ or coping ability	.65	.27	0	.19			
Supernatural beings	.59		.17		.20		
Unlucky or predestined	.58	.26		0		.16	
Lacks formal education	.55			.31	.13	0	.20
Infected by bacteria or germs	.54		.16		.25	0	.19
Genetic predisposition	.45	0	.20			.41	0
Brain or nervous sys. problem	.44		.30	0			.41
Work/study environ. not good		.67		.15			
Too many defeats in life		.59	.25		0	.23	
Too poor & unsatisfied with life	.26	.56	.25	0	.22		.16
Overworked		.55		.24	.14	.16	.36
Discord co-workers or friends		.51	.18	.46	.24		0
Problem in past (upbringing)	.23	.35		.16	.19	.27	
Lost someone close			.73	.11			.15
Marital problems	.11	.23	.73	.13	.13		
Discordant fam. life		.34	.66	.25	.27		
Due to menopause	.11		.51	0		.12	.29
Lacks spiritual beliefs	0		.23	.71		.19	
Lacks willpower, too soft	.17	.33		.61	0		.18
Neg. influence by media		.20			.77	.15	.20
Influenced by depressed others	.29		.13		.67		
Lifestyle odd or different	.26			.29	.37		.35
Too educated or affluent					.14	.76	.11
Low status vs expectations		.26	.13	.12		.65	
Poor health or low resistance	.13	.15	.10	.27	.21		.64
Bad living environment	.33	.23	.21			.15	.45

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.

[32] The explained variances reported for each component are those for the rotated solution, not those for the initial extraction.

Also of interest with respect to the 'Environmental Stress - Downtrodden' Causal Factor, was that it subsumed one of the two items that failed to show a significant factor loading (i.e., greater than 0.4) with any causal factor; 'problem in the past (upbringing)'. The most likely explanation for this loading, non-significant though it was, is that the item was perceived as conceptually related to 'environmental factors'.

The third factor was labelled 'Family Problems' and accounted for 5.92% of the total variance. This factor included such items as 'the loss of someone close' and 'marital problems' and 'discordant family life'. It is interesting to note that factor 3 also loaded significantly on the item: 'the problem is caused by menopause'. Intuitively, one might expect this item to load most significantly with the 'Biological - Fatalistic' factor, given its conceptualisation as an inevitable and normal biological consequence of ageing. The fact that the 'Family Problems' factor loaded significantly on this item suggests that menopause may be perceived as a problem with its chief impact being observed or felt in the context of the family.

The fourth factor, accounting for 5.33% of the overall variance, was labelled 'Lacks Inner Resources'. This factor showed significant loadings on the items; 'lacks willpower – too soft (person)' and 'lacks spiritual beliefs', and implied a characterological or 'philosophical' deficiency. Focus group participants' descriptions relating to the first item suggested a weak or fragile disposition rather than simply a lack of resolve per se. The term elicited from the focus groups (and used in the questionnaire) suggested an individual displaying a character similar to the Western concept of the 'neurotic' personality. With regard to the second attribution, it is important to note that, in the context of the focus groups, the 'spiritual beliefs' item did not necessarily connote religious beliefs. Rather, it held a more general meaning that implied having a defining and sustaining life philosophy that is consonant with a formalised system of guiding

principles (this could be anything from Christianity or Confucianism to Capitalism or Communism).

The fifth factor, which accounted for 4.6% of the variance, was entitled 'Negative - Depressing Influences'. Attributions on which this factor loaded significantly were; 'influenced by negative media' and 'influenced by depressed others'. Focus group participants described the 'media' item as including television, books, magazines, etc., reflecting such things as depressing or sad themes, or depicting suffering. The latter item suggests that interaction with depressed people may cause or exacerbate depression. This factor also included the second item on which no factor loaded significantly: 'lifestyle odd or different'. It is possible that subjects perceived that individuals leading an odd or different lifestyle may gravitate toward, or possess a propinquity with depressed others in their milieu and/or may have a penchant for negative or depressing themes in their media choices.

The sixth Causal Factor was labelled 'Unfulfilled Aspirations'. This factor accounted for 4.2% of the total variance and included items implying that the individual fell short of fulfilment or attainment of some lifestyle ideal. This factor loaded significantly on items including; the person's 'actual life status is too far below his or her expectations' and 's/he is too highly educated or affluent'. Participants in the focus groups suggested that the former item reflected the reality that some people are assigned to, or achieve, stations in life below what they may have expected to achieve through such things as education and/or experience, or through long and dedicated service. The latter item reflected the idea that some people are very highly educated or affluent and are never satisfied with their lot in life. In other words, no matter how much they may attain, it is never enough to satisfy them.

As mentioned in relation to the 'Biological-Fatalistic' factor, factor 6 (Unfulfilled Aspirations) also loaded significantly on the item 'genetic predisposition'. The association between unfulfilled aspirations and genetic predisposition is not entirely clear. It is possible that some subjects viewed genetic predisposition more in terms of a social sense of 'lineage' whereby, for example, members of pre-revolution 'upper class' families may be perceived as expecting an 'entitlement' beyond the station they currently hold in post-revolution China. Admittedly, this is a long conceptual leap. However, it does address this somewhat anomalous finding.

The seventh and final factor, accounting for 3.97% of the total variance, was labelled 'Poor Health/Environment' since it loaded significantly on the following causes: 'poor health or low resistance to germs' and 'bad living environment'. These items suggest some deficiency in the individual's standard of living. As described by focus group participants these items reflect sequelae of such things as current or childhood impoverishment. As mentioned in the description of the 'Biological-Fatalistic' factor, the item 'brain or nervous system problem' also had a lower, but significant, loading on the 'Poor Health/Environment' factor. One possibility for this secondary loading is that subjects associated the 'brain or nervous system problem' item with the 'poor health or low resistance to germs' item. It is also possible that subjects perceived this causal attribution as being a consequence of a deficient or impoverished environment and the significant loading with the 'Poor Health/Environment' reflects this association.

Descriptive statistics for Causal Factor scores

Table 11 shows the means and standard deviations of the Causal Factor scores for the full sample of laypersons. The relatively low standard deviations suggest that there was fairly high consensus among subjects' ratings that contributed to these scores.

Table 11: Means and standard deviations of Causal Factor scores for total lay sample

Causal Factor	Mean	Std. Deviation
Biological - fatalistic	.81	.68
Environmental stress - Downtrodden	1.88	.86
Family problems	2.04	.99
Lacks inner resources	2.45	1.15
Neg-depressing influences	1.08	.97
Unfulfilled aspirations	1.91	1.12
Poor health/environment	1.38	1.02

In Table 11, it is evident that the ZLacks Inner Resources and the 'Family Problems' factors were rated by the overall lay sample as the most important causes of depression. The standard deviations suggest that there was somewhat greater consensus with respect to the 'Family Problems' versus the ZLacks Inner Resources Causal Factors. The 'Unfulfilled Aspirations' and 'Environmental Stress - Downtrodden' factors also showed relatively high ratings, although the mean ratings of these Causal Factors did not reach the threshold for importance. It is interesting to note that the 'Biological - Fatalistic' cause factor was rated lowest. This would seem to indicate that the 'depressive' disorder depicted in the vignette was not perceived as being of a physiological or a supernatural nature. It may be surmised from this comparison that the lay subjects surveyed viewed this as a condition primarily caused by internal non-biological deficiencies combined with stresses due to discord in the social environment.

Health Care Professionals' Ratings of Causal Attributions

Due to the small size of the professional sample (98 completed questionnaires), factor analysis was not considered a valid approach to examining these results (Comrey, &

Lee, 1992). As such, the discussion of the results of the professional causal beliefs was limited to an examination of descriptive statistics at the item level.

An examination of Table 12 reveals that, unlike their lay counterparts, professional subjects rated only seven of the attributions as important causes of depression. However, there was substantial overlap between the lay and professional endorsements. Again, using the arbitrary threshold value of 2.0, the three attributions most highly rated by professionals as causes of depression were; 1) the individual has lost someone close, 2) the individual is experiencing discord with co-workers or friends, and 3) the individual lacks spiritual beliefs.

There were two items on which ratings by professional subjects and lay subjects did not overlap. Professional subjects rated 'menopause' as an important cause of depression, whereas lay subjects rated this item as only moderately important. Lay subjects rated 'discordant family life' as an important cause of depression, whereas professional subjects rated it as only moderately important. However, this latter difference was very small and the professional subjects' rating of this causal attribution (1.97) was barely below the arbitrary threshold for 'importance'.

The causes rated lowest by professional subjects, for the most part, mirrored those of their lay counterparts. These low rated attributions included; 'supernatural beings', 'infected by bacteria or germs', 'lacks IQ or coping ability', 'lacks formal education', and 'unlucky or predestined'. The Chinese health care professionals surveyed rated the 'genetic predisposition' and the 'brain or nervous system' higher than did their lay counterparts however differences on the latter item were minor. This lends partial support to Pearson's (1993) contention regarding the contrast between lay and

professional beliefs about mental disorders (i.e., that professionals are more inclined toward biomedical explanations than are lay people).

Table 12: Means and standard deviations of health care professionals' ratings of causal attributions

Causal Attribution	Mean	Std. Deviation
Genetic predisposition	1.07	1.06
Too educated or affluent	1.19	1.26
Low status vs expectations	1.90	1.26
Due to menopause	2.05	1.27
Lost someone close	2.12	1.31
Unlucky or predestined	.63	1.12
Too many defeats in life	2.04	1.10
Brain or nervous sys. problem	1.48	1.51
Too poor & unsatisfied with life	1.42	1.15
Lacks IQ or coping ability	.45	.86
Problem in past (upbringing)	1.38	1.28
Neg. influence by media	.72	.94
Influenced by depressed others	.71	.99
Marital problems	2.06	1.23
Work/study environ. not good	1.80	1.15
Overworked	2.03	1.18
Poor health or low resistance	1.13	1.08
Supernatural beings	.19	.55
Discordant fam. life	1.97	1.16
Discord co-workers or friends	2.12	1.22
Lacks willpower, too soft	1.94	1.26
Bad living environment	.92	.95
Infected by bacteria or germs	.26	.74
Lacks formal education	.45	.91
Lifestyle odd or different	.77	.98
Lacks spiritual beliefs	2.09	1.42

It was interesting to note that, as with lay people, professional subjects also rated 'genetic predisposition' quite low as causal in depression. This seems to suggest that Chinese professionals and lay people alike conceptualise depression differently from the 'genetic' diathesis model held by some healthcare professionals in the West.

Question #2: Which help seeking alternatives for depression are rated most highly by Chinese lay people?

Lay People's Ratings of Help Seeking Preferences

Descriptive statistics for help seeking preferences scale

Table 13 shows the means and standard deviations of subjects' ratings of help seeking preferences. Again, as seen in the standard deviations, there was significant variability in consensus among subjects as to their preferences for the various help seeking alternatives included in this scale.

It is notable that the most highly favoured source of help was 'psychologist' given the scarceness of this resource in China. Self-help was the second most highly rated approach to overcoming depression. As would be expected from the literature reviewed earlier on Chinese help seeking, Friends and Family members were also rated as desirable sources of help for depressed persons. The reasons for these ratings will be explored further in the conclusions and discussion section.

Consistent with subjects' ratings of causal beliefs, it is not as surprising to see Shaman and Temple/priest having been rated as low as they were. Also notable was the low rating given Acupuncturist. This is counterintuitive given high rating accorded TCM doctors and with the widespread use of this form of help, generally, in Chinese society. It may be that subjects distinguish between physicians trained in the full range of TCM and those whose training is limited to acupuncture, and eschewed the latter due to the more limited scope of their knowledge and practice. This finding may also reflect the current reality in China. There are individuals who practice acupuncture (and other forms of healing) without the appropriate training. Thus, the perception of acupuncturists generally may be tainted by highly-publicised cases of such charlatanism.

Table 13: Means and standard deviations of ratings of help seeking alternatives for total sample

Help Seeking Alternative	Mean	Std. Deviation
Do nothing (hope it goes away)	1.04	1.14
Acupuncturist	.94	1.06
Barefoot doctor	.66	1.02
Family member	2.46	1.18
Friend	2.55	1.22
Folk healer	.39	.87
Herbalist	1.40	1.19
Massage therapist	1.31	1.17
Community health nurse	1.26	1.25
Psychiatrist	1.72	1.52
Psychologist	2.80	1.29
Shaman	.37	.93
Self-help (exercise, educ'n)	2.78	1.16
TCM Doctor	1.66	1.31
Temple/priest	.63	1.02
Western MD	1.39	1.33

Factor analysis of help seeking preferences

Table 14 shows the result of the Principal Components extraction with Varimax rotation for lay peoples' ratings on the help seeking preference scale. The analysis yielded a clearly interpretable four-factor structure, which accounted for 54.17% of the variance among ratings of items on this scale.

The first factor, which accounted for 24.25% of the total variance, was labelled 'Traditional/Western medical'. This factor showed significant loadings on help seeking alternatives that reflected biomedical sources of help. These included the full range of TCM practitioners and Western medical practitioners. In the context of the Chinese medical system massage therapists are subsumed under TCM approaches and most

hospitals and clinics have a department that offers therapeutic massage including acupressure therapy, which is closely associated with acupuncture. Therefore, it is understandable that massage therapist would cluster with the other medical specialties.

The second factor was labelled 'Supernatural/folk' and accounted for 11.42% of the total variance. This factor loaded significantly on items that generally reflected a range of help seeking alternatives that fall outside the mantle of currently accepted therapeutic practice such as Shaman and Temple/priest. The one exception was the item 'Barefoot doctor'. Since subjects were asked to endorse help seeking alternatives specifically with regard to 'depression', it would be expected these ratings reflected their perception of the efficacy of this form of help with regard to this disorder. Therefore, this loading may suggest that barefoot doctors are perceived as being ill equipped in the modern medical sense to deal with problems such as depression. An other possible explanation for this loading is that, since a large proportion of the total sample was drawn from urban populations, these subjects may perceive barefoot doctors as being outside the currently accepted realm of helping resources, viewing them as 'folk' practitioners.

Also with respect to the 'Barefoot doctor' item, this was the only double loading item in the help seeking preference scale. As can be seen in Table 14, the Traditional/Western medical factor also loaded significantly on this helping resource. This seems to reflect an ambivalent attitude toward barefoot doctors whereby they are viewed as a formal type of medical help by some subjects and as a folk resource by others subjects.

Table 14: Rotated component matrix of Lay people's ratings of help seeking preferences

	Component			
Help Seeking Alternative	1	2	3	4
Herbalist	.81			
TCM Doctor	.79			
Western MD	.72		-.14	.23
Massage therapist	.71		.22	
Acupuncturist	.68	.14		
Community health nurse	.61			.33
Shaman		.78		
Folk healer	.25	.62		
Temple/priest		.58	.19	.12
Barefoot doctor	.47	.49		
Do nothing (hope it goes away)		.45		-.10
Friend			.87	
Family member		.19	.73	.19
Self-help (exercise, educ'n)		-.15	.47	-.38
Psychiatrist	.19			.83
Psychologist		-.23	.26	.69

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.

Interestingly, the Supernatural/folk factor also loaded significantly on the item 'do nothing (hope it goes away)'. This may indicate that subjects perceived doing nothing as a form of 'faith' based healing. Conversely, it may be that, since subjects endorsed doing nothing in patterns similar to the endorsement of the other items loading with this factor, these other means of intervention may be perceived as 'passive' approaches to dealing with the problem depicted in the vignette.

The third Help-seeking Factor, which accounted for 10.57% of the total variance, was labelled 'Social support/self-help'. This factor showed significant loadings on the 'Friend', 'Family member' and 'Self-help' helping resources. The meanings of the

'Friend' and 'Family member' help seeking alternatives items are clear (and ubiquitous in the help seeking literature) and would be expected to cluster together.

In the context of the focus groups, the self-help item reflected an intentional and active approach to overcoming depression. Focus group participants suggested that such things as vacations, exercise classes and taking self-improvement courses (either educational or avocational) might help depressed individuals by distracting them from their problems, relieving stress and improving general physical and psychological well-being.

The fact that the family member, friend and self-help alternatives clustered together may also reflect the Chinese tendency toward secrecy when psychological problems are encountered. Limiting one's attempts at overcoming a problem such as depression to self-help or sharing it with family or friends would ensure, to greater or lesser degrees, the non-disclosure of such confidential information.

The fourth factor was labelled 'Mental health professional'. This factor accounted for 7.93% of the total variance. The Mental health professional factor loaded significantly on the items Psychologist and Psychiatrist. Both logic and the literature reviewed on help seeking for psychological problems among Chinese, suggests that these approaches to dealing with depression would cluster together.

Descriptive statistics for Help-seeking Factor scores

Table 15 shows the descriptive statistics for subjects' ratings of the Help-seeking Factor scores. This table shows that the most highly endorsed Help Seeking factors for depression were Social support/self-help and Mental health professionals. The results displayed suggest that while these two categories of help seeking resources were almost equally rated, there was a somewhat higher consensus among subjects (as reflected in the

standard deviations) regarding the Social support/self-help factor than there was for the Mental health professional factor.

Table 15: Means and standard deviations of Help-seeking Factor scores of total Lay sample

Help Seeking Factor	Mean	Std. Deviation
Tradidional/Western medical	1.33	.90
Supernatural/folk	.62	.60
Social support/self-help	2.60	.85
Mental health professional	2.26	1.19

With respect to this latter finding, given the difference in the endorsements of psychiatrist versus psychologist, it is not surprising to see that there was lower consensus around mental health professionals as preferable sources of help for depression. The reasons for this finding will be explored in the discussion section below.

Question #3: Is there a relationship between Chinese lay people's ratings of causal attributions and those of help seeking preferences for depression?

Relationship Between ratings of Causal and Help-seeking Factors

As mentioned earlier, Spearman's rank order correlation coefficients were calculated to evaluate the relationship between Causal Factor scores and help seeking preference Factor scores. As would be expected in any such analysis there were some correlations that were statistically significant but marginal in their practical significance. A visual examination of Table 16 reveals that the majority of the correlations between Causal Attribution Factor scores and Help Seeking Factor scores were significant at the $p < .01$ level or better.

Table 16: Spearman Rank Order Correlations for Causal Attribution Factor Scores and Help-seeking Factor Scores for Lay sample

		Help Seeking Factor			
Causal Factor		Tradidional/Westem medical	Supernatural/folk	Social support/self-help	Mental health professional
Biological - fatalistic	Correlation Coefficient	.386**	.406**	.005	.180**
	Sig. (2-tailed)	.000	.000	.917	.000
	N	492	492	492	492
Environmental stress - Downtrodden	Correlation Coefficient	.161**	.094*	.222**	.145**
	Sig. (2-tailed)	.000	.037	.000	.001
	N	492	492	492	492
Family problems	Correlation Coefficient	.173**	.180**	.215**	.095*
	Sig. (2-tailed)	.000	.000	.000	.035
	N	492	492	492	492
Lacks inner resources	Correlation Coefficient	.026	-.019	.253**	.164**
	Sig. (2-tailed)	.559	.672	.000	.000
	N	492	492	492	492
Neg-depressing influences	Correlation Coefficient	.181**	.140**	.111*	.098*
	Sig. (2-tailed)	.000	.002	.014	.031
	N	492	492	492	492
Unfulfilled aspirations	Correlation Coefficient	-.024	.074	.213**	.066
	Sig. (2-tailed)	.600	.103	.000	.143
	N	492	492	492	492
Poor health/environment	Correlation Coefficient	.361**	.303**	.085	.082
	Sig. (2-tailed)	.000	.000	.060	.069
	N	492	492	492	492

** Correlation is significant at the .01 level (2-tailed).

* Correlation is significant at the .05 level (2-tailed).

These correlations indicate that there is a strong and, in some cases, predictable relationship between scores on the Causal Factors and the Help-seeking Factors. These relationships will be examined more closely in the discussion section.

Question #4: Is there a relationship between subjects' scores on the Chinese Depression Inventory and their ratings of Causal Factors for depression and/or their ratings of Help-seeking Factors?

Relationship Between Level of Depressive Symptoms and Causal Factors

In order to examine the relationship between the level of depressive symptoms and the Causal Factors, subgroups were derived based on the subject's current classification with respect to scores on the Chinese Depression Inventory.

Table 17: Spearman's Rank Order Correlations between Causal Factor Scores and Severity of Depression

Causal Factor		Severity of depression
Biological - fatalistic	Correlation Coefficient	.222**
	Sig. (2-tailed)	.000
	N	492
Environmental stress - Downtrodden	Correlation Coefficient	.164**
	Sig. (2-tailed)	.000
	N	492
Family problems	Correlation Coefficient	.140**
	Sig. (2-tailed)	.002
	N	492
Lacks inner resources	Correlation Coefficient	.021
	Sig. (2-tailed)	.646
	N	492
Neg-depressing influences	Correlation Coefficient	.128**
	Sig. (2-tailed)	.005
	N	492
Unfulfilled aspirations	Correlation Coefficient	.062
	Sig. (2-tailed)	.173
	N	492
Poor health/environment	Correlation Coefficient	.121**
	Sig. (2-tailed)	.007
	N	492

**. Correlation is significant at the .01 level (2-tailed).

As is evident from an examination of Table 17, the level of depressive symptoms (measured by the CDI) showed significant correlations with the Causal Factors in this study. The strongest correlation was between depression and scores on the Biological – fatalistic Causal Factor. Weaker, but statistically significant, correlations were found between depression and all but two of the other Causal Factors.

This analysis clearly shows a relationship between the severity of depression and ratings on the causal attribution scale. To further illuminate this relationship, mean Causal Factor scores were analysed based on the levels of depressive symptoms.

Table 18: Mean Causal Factor scores analysed by level of depressive symptoms

	Severity of depression			
	Normal	Mild	Moderate	Severe
Cause Factor	Mean	Mean	Mean	Mean
Biological - fatalistic	.72	.73	1.11	1.38
Environmental stress - Downtrodden	1.78	1.96	2.13	2.25
Family problems	1.95	2.10	2.36	2.33
Lacks inner resources	2.42	2.52	2.49	2.47
Neg-depressing influences	.98	1.32	1.18	1.21
Unfulfilled aspirations	1.86	2.06	1.85	2.09
Poor health/environment	1.29	1.41	1.70	1.67

Table 18 reveals several interesting trends. First, as a general statement those with higher levels of depression tended to give higher ratings overall to most of the Causal Factors. These differences were most pronounced with respect to the normal versus the other three categories of depressed individuals. Although none of the groups rated the Biological - fatalistic, the Negative - depressing influences or the Poor Health/Environment Causal Factors highly as causes of depression, moderately and severely depressed subjects were more likely than members of the other two groups to do so. The two most severely depressed groups rated the Environmental Stress - Downtrodden Causal Factor as important whereas the normal and mildly depressed groups did not.

As might be expected from the overall results of the analysis causal attributions described above, the greatest degree of consensus and the highest ratings were accorded

the 'Lacks Inner Resources' and the 'Family Problems' Causal Factors. However, the non-depressed group's rating of this latter Causal Factor was below the threshold for importance. With regard to the Unfulfilled Aspirations Causal Factor, the mildly and severely depressed rated this as a significant cause, whereas the normal and moderately depressed groups did not.

These results support the hypothesis that level of depressive symptoms do, indeed, influence ratings of causal attributions for depression.

Relationship Between Level of Depressive Symptoms and Help Seeking Factors

Table 19 shows the correlations between severity of depression and Help-seeking Factor scores. All but one of the correlations reached statistical significance. Although in a practical sense, these relationships were weak.

As was done with the Causal Factors, in order to more clearly illuminate the relationship between Help-seeking Factors and severity of depression, mean ratings for each Help-seeking Factor were analysed by severity of depression. Table 20 presents this analysis.

Table 19: Spearman's Rank Order Correlations between Help-seeking Factor Scores and Severity of Depression

Help Seeking Factor		Severity of depression
Tradidional/Western medical	Correlation Coefficient	.140**
	Sig. (2-tailed)	.002
	N	492
Supernatural/folk	Correlation Coefficient	.166**
	Sig. (2-tailed)	.000
	N	492
Social support/self-help	Correlation Coefficient	-.127**
	Sig. (2-tailed)	.005
	N	492
Mental health professional	Correlation Coefficient	.035
	Sig. (2-tailed)	.437
	N	492

**. Correlation is significant at the .01 level (2-tailed).

Table 20 reveals a familiar trend with respect to the first two Help-seeking Factors. While neither of these factors were rated as desirable sources of help, ratings of them increased with increasing severity of depressive symptoms. The inverse relationship seen in Table 19 between the level of depression and endorsement of the Social support/self-help factor is clearly illustrated in Table 20. Although rated somewhat as less preferable than Social support/self-help, the Mental health factor received relatively uniform endorsement as a desirable helping resource.

Table 20: Mean Help-seeking Factor scores analysed by level of depressive symptoms

	Severity of depression			
	Normal	Mild	Moderate	Severe
	Mean	Mean	Mean	Mean
Tradidional/Western medical	1.23	1.49	1.53	1.47
Supernatural/folk	.55	.55	.82	1.07
Social support/self-help	2.67	2.50	2.56	2.29
Mental health professional	2.22	2.39	2.30	2.22

These results support the hypothesis that the level of depressive symptoms exerts an impact on ratings of help seeking preferences. However, though the results are statistically significant this effect appears to be mild in a practical sense.

Question #5: Does clinical status affect subjects' ratings of Causal Factors for depression and/or their ratings of Help-seeking Factors?

While the CDI differentiated between subjects based on their current level of depressive symptoms, this does not address the question of the effect of treatment history on ratings of Causal Factors or Help-seeking Factors. Therefore, the data were analysed based on the subject's clinical status. This was defined as whether or not the subject was currently an inpatient or outpatient in active treatment for depression.

Relationship Between Clinical Status and Causal Factors

Table 21 shows the correlations between Causal Factor scores and clinical status. Only three of the seven correlations reached statistical significance.

Those correlations that did reach statistical significance indicated an inverse relationship. Clinical status was a dichotomous variable with 0 (zero) indicating non-clinical subjects and 1 (one) indicating clinical subjects. Therefore, the positive correlations indicate that clinical subjects rated a given Causal Factor higher than did non-clinical subjects.

Table 21: Spearman's Rank Order Correlations between Causal Factor Scores and Clinical Status

Causal Factor		Clinical Status
Biological - fatalistic	Correlation Coefficient	.019
	Sig. (2-tailed)	.669
	N	492
Environmental stress - Downtrodden	Correlation Coefficient	-.099*
	Sig. (2-tailed)	.028
	N	492
Family problems	Correlation Coefficient	-.227**
	Sig. (2-tailed)	.000
	N	492
Lacks inner resources	Correlation Coefficient	-.085
	Sig. (2-tailed)	.059
	N	492
Neg-depressing influences	Correlation Coefficient	-.079
	Sig. (2-tailed)	.081
	N	492
Unfulfilled aspirations	Correlation Coefficient	-.116**
	Sig. (2-tailed)	.010
	N	492
Poor health/environment	Correlation Coefficient	-.074
	Sig. (2-tailed)	.102
	N	492

*. Correlation is significant at the .05 level (2-tailed).

**. Correlation is significant at the .01 level (2-tailed).

Table 22 contains the mean Causal Factor scores analysed by clinical status. The most pronounced difference is seen in relation to the 'Family Problems' Causal factor. This result indicates that the clinical subjects were less likely to endorse family problems as important in causing depression than were their non-clinical counterparts. The same, though weaker, relationship existed between clinical status and the Environmental Stress - Downtrodden and the Unfulfilled Aspirations Causal Factors.

Table 22: Lay people's Mean Causal Factor scores analysed by clinical status

	Clinical Status	
	Non-clinical	Clinical
Causal Factor	Mean	Mean
Biological - fatalistic	.81	.83
Environmental stress - Downtrodden	1.91	1.71
Family problems	2.14	1.52
Lacks inner resources	2.49	2.24
Neg-depressing influences	1.11	.94
Unfulfilled aspirations	1.97	1.64
Poor health/environment	1.42	1.21

These results suggest that while there is an effect of clinical status on ratings of the Causal Factors it is not as pronounced as the effect of depressive symptoms.

Relationship Between Clinical Status and Help Seeking Factors

Table 23 shows the correlations between clinical status and Help-seeking Factor scores. All four correlations were statistically significant. Again, given the coding scheme for clinical status, positive correlations indicate that clinical subjects were more likely to endorse the given Help-seeking Factor than non-clinical subjects were.

The results seen in Table 23 indicate that clinical subjects were more likely than were their non-clinical counterparts to endorse Traditional or Western medical resources and mental health professionals as desirable sources of help in overcoming depression. Conversely, clinical subjects were less likely than were their non-clinical counterparts to endorse Supernatural/folk and Social support/self-help as desirable sources of help.

Table 23: Spearman's Rank Order Correlations between Help-seeking Factor Scores and Clinical Status

Help seeking Factor		Clinical Status
Tradidional/Western medical	Correlation Coefficient	.219**
	Sig. (2-tailed)	.000
	N	492
Supernatural/folk	Correlation Coefficient	-.103*
	Sig. (2-tailed)	.022
	N	492
Social support/self-help	Correlation Coefficient	-.134**
	Sig. (2-tailed)	.003
	N	492
Mental health professional	Correlation Coefficient	.264**
	Sig. (2-tailed)	.000
	N	492

**. Correlation is significant at the .01 level (2-tailed).

*. Correlation is significant at the .05 level (2-tailed).

This finding is reflected in the mean ratings of the Help-seeking Factor scores illustrated in Table 24. Neither group endorsed Traditional/Western medical or Supernatural/folk helping resources as sources of help they might pursue in overcoming depression. On the other hand, both groups indicated that they would utilise approaches that included social support and/or self-help and seek the assistance of mental health professionals if faced with depression.

Table 24: Lay people's Help-seeking Factor scores analysed by clinical status

	Clinical Status	
	Non-clinical	Clinical
Help Seeking Factor	Mean	Mean
Tradidional/Western medical	1.25	1.73
Supernatural/folk	.64	.47
Social support/self-help	2.65	2.31
Mental health professional	2.12	2.96

These results support the hypothesis that experience in the mental health system significantly impacts subjects' ratings of various helping resources.

Chapter 5 - Conclusions and Discussion

Several broad conclusions can be drawn from the current research. What the current study has shown is that there is both a 'core' set of causal beliefs and help seeking preferences that cuts across cultures, as well as a particularly Chinese subset of these beliefs and preferences. Further, there is a significant effect of current level of depressive symptoms and of clinical status on causal beliefs and help seeking preferences.

Ratings of Causal Attributions

The current study reveals that Chinese lay people subscribe to a primarily psychosocial, rather than a biological or supernatural causal model of depression. The high mean rating found for the ZLacks Inner Resources Causal Factor suggests that the principal cause of depression is seen as something internal to the individual, though not necessarily within his or her control. The 'Lacks Inner Resources' factor represents deficits in such things as character and guiding philosophical or religious beliefs.

In this context, one of the more remarkable findings in the current study was the importance that both lay and professional subjects assigned to a 'lack of spiritual beliefs' in the aetiology of depression.

This finding suggests at least two different interpretations. The first possibility is that, currently, Chinese people see depression as caused by insufficient resort or dedication to a sustaining life philosophy. In this sense, this finding would reflect the notion that subjects perceived that the individual depicted in the vignette was deficient in his or her beliefs and that this led to depression. This would suggest that subjects perceived a role for enhancement of such beliefs or philosophies in overcoming depression. This is akin

to the idea that advocated for overcoming neurasthenia that was espoused by the Chinese mental health establishment during the Cultural Revolution

However, a second possibility is that this finding could reflect a more global attribution of depressogenicity. It may be that subjects were identifying with and reacting to the stimulus person's difficulties and projecting social problems onto it as a way of identifying how s/he came to be in this condition. In other words, the question arises as to whether subjects were rating pure causal factors in depression, or were they identifying conditions in their own milieu that would lead one to become depressed.

In either case, this finding is reminiscent of the assertion by Durkheim (1951) regarding the relationship between anomie and suicide[33]. As mentioned earlier, in the construction of the causal beliefs scale, focus group participants indicated that the spiritual beliefs item should not be interpreted strictly as connoting religious beliefs. Instead, they emphasised a wider interpretation that included any set of guiding principles (including religious, political, philosophical, etc.). Durkheim referred to a loss of moral and philosophical rules and beliefs as a key factor in the dissolution of social cohesion that led to the state he termed anomie.

It is possible that some subjects associated the syndrome depicted in the vignette with a state of normlessness that many Chinese may be experiencing because of rapid social change in that country. Old and accepted institutions and values are being dismantled and viable substitutes have yet to appear to take their place. One of the sequelae of this anomic phenomenon may be found in the various mainstream and fringe religions that

[33] Durkheim did not refer specifically to the disorder we know as depression in his writing. However, it is reasonable to assume that depression is implied as a concomitant of anomie and suicide.

have gained wider acceptance within the past five to ten years among the predominantly 'secular' population of China.

The second component of the 'Lacks Inner Resources' Causal Factor is the item 'Lacks willpower (too soft)'. As mentioned above, the participants in the focus groups said that this attribution suggests that the individual is inherently weak or fragile in character. In other words, a person who is prone to excessive anxiety and/or emotional upset. The individual item analysis indicated that lay people rated this item as important and professionals rated it as moderately important in the aetiology of depression. This finding seems to suggest that the Chinese subjects in this study recognised a 'depression prone' personality configuration and rated this highly as an aetiological factor in depression.

This finding also supports those of earlier studies (e.g., Nunnaly, 1961; Arkoff, Thaver and Elkind, 1966; Sue, Wagner, Ja, Margullis, & Lew, 1976) regarding the importance of a lack of willpower as a predisposing factor in mental illness. As noted earlier, Sue et al suggested that the belief that deficits in willpower may cause mental disorder likely reflects the Chinese emphasis on self-control as a fundamental personal attribute.

Taken together the items that constitute the ZLacks Inner Resources Causal Factor could also be construed as the first component in the diathesis-stress model of depression. Beck's diathesis-stress model of depression (Beck, Rush, Shaw, & Emery, 1979), suggests that early experience may inculcate maladaptive cognitive schemas. These schemas predispose some individuals to interpret stressful situations in ways that increase the possibility that they will develop a major depressive disorder in response to stress. Viewed in this way, Chinese beliefs about the causes of depression could be

considered as highly congruent with current psychological theories of depression widely held in the West.

These characterological or philosophical deficits were accompanied by significantly high ratings on the 'Family Problems' Causal Factor. The family problems Causal factor consisted of the items; loss of someone close, marital problems, discordant family life and menopause. The family has traditionally been seen as one of the primary forces undergirding Chinese society. Thus, it may be expected that problems within the family would be viewed as depressogenic.

The loss of a loved one has long been recognised as one of life's greatest stressors (Dohrenwend, & Dohrenwend, 1974). Similarly, marital and family discord and the attendant loss of support has been recognised for its influence on depression (e.g., Brown, 1993). Finally, the question of the aetiological role of menopause in depression has long been answered anecdotally. The role of hormonal changes inherent in menopause has not been found to be as significant as the other life stresses that occur at this stage in human development (for a comprehensive review see, Formanek, 1987). Nonetheless, all of these factors have been linked to depression either scientifically or in the popular understanding of the disorder. Thus, again, the high rating accorded the 'Family Problems' Causal Factor is consistent with the aetiological perspective held in the West regarding this disorder.

Professional's ratings of causes of depression

Professionals rated components of the 'Family Problems' Causal Factor as significant causes of depression. It is interesting that these professionals' number one rated cause of depression was the loss of someone close. Again, this is consistent with Western perceptions of the depressogenicity of interpersonal loss. The comments above in

relation to this Causal Factor are also applicable to the current discussion of health care professional's ratings. Also interesting is the fact that professionals rated components of both the Environmental Stress - Downtrodden Causal Factor and the 'Lacks Inner Resources' Causal Factors as equally important in causing depression. This suggests two things. First, as with their lay counterparts, these professionals seem to adhere to a psychosocial rather than a biological causal model of depression. Second, the similarities in these ratings suggest that the professional and lay conceptualisations of depression are quite congruent.

It is also interesting that these Chinese professionals eschewed a biological and/or genetic interpretation of depression. In the genetic diathesis model, a genetic (or neurological) predisposition acts in concert with environmental stress to produce depression. While mental health professionals in the West would likely differ in their estimation of the effect of genetic predisposition on depression, few would rule it out entirely. While the current sample of professionals did not rate neurological and genetic factors as low as did their lay counterparts, their ratings do not suggest that they perceived an important role for such factors in the aetiology of depression.

Ratings of Help Seeking Preferences

The ratings of help seeking alternatives yielded some surprising and some expected results. The highest ratings being garnered for 'psychologist' and 'self-help' requires further examination. The high endorsement of 'self-help' seen in Table 13 is very consistent with other findings in the literature suggesting a high propensity toward self-reliance among Chinese in dealing with problems such as depression (e.g., Cheung, Lau, & Wong, 1982). In addition, there is a burgeoning list of popular self-help psychology books now available in Chinese bookstores. This may have bolstered the perception

among subjects that self-help is a viable first alternative when trying to overcome depression.

'Friend' and 'Family member' followed these as the most highly rated sources of help. Again, this is quite consistent with other findings regarding the Chinese tendency toward first consulting family and/or friends when confronting psychological problems (e.g., Ying, 1991). This leaves the question of the high ratings given psychologists.

That psychologist would be rated highest among potential sources of help for depression is quite surprising. One possible explanation for this result is that it may have been a research artefact due to the design of the questionnaire. In acknowledging the support of the sponsoring department of Beijing university (the psychology department) on the cover page of the questionnaire, subjects may have been cued to the purpose of the study. It was possible that a bias was introduced toward psychologists as a function of this information. However, in addition to the differences based on level of depressive symptoms and on clinical status, analyses based on factors such as age, education and urban versus rural residence also yielded significant differences in the endorsement of psychologist as a desirable source of help. This would seem to suggest that if there was such a biasing effect it was minimal and/or impacted these endorsements differentially across the various demographic groups.

A second argument is that if such cueing or priming occurred, one may have expected that psychiatrists would also have been highly rated as sources of help since they are both parts of the formal mental health care structure. As most psychologists and psychiatrists in the West would attest, only a small minority of even highly educated individuals outside the mental health community have a clear understanding of the distinction between these two disciplines. Therefore, it is unlikely that in China, where

formal mental health services are still a relatively rare commodity, that the average layperson has a clearer understanding of this distinction. Thus, the 'cuing' hypothesis becomes less tenable as a rationale for this finding.

A second possible explanation for this result may lie in the recent exposure that psychology has had in the popular media. In addition to the above noted proliferation of psychological self-help books, in China, at the time the current study was conducted, there were many magazine and newspaper articles reflecting psychological themes. Also, during this period there was a popular weekly radio programme during which the hosts, including psychologists, psychiatrists and medical doctors, answer letters and open-line calls about psychological problems. Thus, psychology has gained a wider audience and popularity than it enjoyed in the past.

The recent media exposure that psychology has enjoyed seems to have provided the discipline with a degree of cachet in modern Chinese society. The author's personal experience has been that many people in China invest psychology with an almost mystical quality. This may reflect an ironic effect of the Cultural Revolution in which psychology was denounced as an imperialist or bourgeois taboo subject. The result of years of exile from the Chinese social, cultural and academic landscapes seems to be that the average Chinese possesses a very limited understanding, and perhaps over-inflated conceptualisation, of psychology.

This popularisation of psychology may be a factor in the high endorsements it received as a potential source of help. However, again, this does not explain why psychiatrist did not enjoy the same ratings as psychologist as a help seeking alternative.

The higher endorsement accorded psychologist over psychiatrist as a desirable source of help may also reflect a general aversion to 'psychiatric' conceptualisations of problems such as depression. It may be that the perception of a problem as requiring psychological intervention is more acceptable than one requiring psychiatric intervention.

This result could also reflect the causal interpretation of the problem depicted in the vignette. As was evident in the examination of causal attributions, these Chinese subjects viewed 'depression' as a multi-determined problem involving a primarily psychosocial aetiology while, at the same time, rejecting biological causal interpretations. Therefore, depression may be perceived as being more amenable to psychological interventions than the more biologically oriented psychiatric treatments.

Another related explanation is contained in the interface between Chinese culture and language. Blowers (1996) described the derivation of the Chinese term for psychology. The original term was 心 理 学 'Xin Li Xue' using the character for xin 心 meaning "heart". The literal translation of the Chinese term for psychology is "studies of principles (or logic) of the heart". The heart is the seat of reason in traditional Chinese medicine (Lin, 1981). Thus, the modern term refers to the study of mentality. The term for psychologist 心 理 学 者 'Xin Li Xue Zhe' (or 心 理 医 生 'Xin Li Yi Sheng') refers to 'one who studies (or treats) problems of the state of mind'. The term for psychiatrist is 精 神 病医 生 'Jing Shen Bing Yi Sheng'. Literally translated this means 'doctor of mental illness'. Given the strong stigma attached to mental illness in Chinese culture, the Chinese term for psychiatrist may convey a more negative connotation. Therefore, it seems likely that even a person not well acquainted with the differences between the two disciplines of psychology and psychiatry may, from the characters used

to represent them, attach a more positive valence to the term psychologist versus a negative valence to the Chinese term for psychiatrist.

Causal Beliefs and Help Seeking Preferences

In the examination of the degree of association between Causal Factor scores and Help-seeking Factor scores, there were also some expected and some unexpected findings. It is not surprising to find that scores on the 'Biological-fatalistic' Causal Factor were strongly correlated with scores on the 'Traditional/Western medical' Help-seeking Factor. Those individuals who perceived that depression was a function of biological factors would be expected to seek out biomedical interventions. In addition, while it was not contrary to expectation, it was somewhat surprising to see the magnitude of the correlation between this Causal Factor and the 'Supernatural/folk' Help-seeking Factor. In fact, this was the strongest correlation in the current analysis. Again, it makes intuitive sense that subjects perceiving depression as being caused by supernatural influences would seek out faith based remedies.

The correlation between the 'Biological-fatalistic' Causal Factor and the 'Mental health professional' Help-seeking Factor was statistically significant but relatively weak. Thus, individuals with a biological or supernatural conceptualisation of depression would be unlikely to seek out mental health professionals to overcome depression.

This result supports the findings of other researchers (e.g., Ying, 1990, and Cheung, 1987). These studies revealed that individuals holding biological (or somatic) conceptualisations of mental illness were the least likely to seek the aid of mental health professionals. Conversely, they found that those who held psychological conceptualisations were more likely to seek such interventions. If it turns out that rural

Chinese are more likely to hold such conceptualisations of depression, this constitutes a significant problem for the effective treatment of depression.

The 'Environmental Stress - Downtrodden' Causal Factor correlated significantly but weakly with all of the Help-seeking Factors. This result is interesting in that the items that constitute this factor are largely global in their impact and relatively stable in the current Chinese context. 'Social support/self-help' was most highly correlated with the Environmental Stress - Downtrodden Causal Factor. Again, it makes intuitive sense that individuals suffering from problems at work, school etc. would seek counsel and solace from family members and friends. Similarly, where such problems are seen as the cause of depression, self-improvement and/or distraction are likely to be seen as helpful.

The correlations between the 'Environmental Stress - Downtrodden' Causal Factor and the medical and mental health helping resources were also statistically significant. While these correlations were rather weak in a practical sense, they suggest two things. First, it is common in Chinese culture to utilise TCM interventions to boost the body's defences under stressful circumstances. Thus, this correlation would seem, in part, to support the prophylactic and/or restorative role of TCM (Lin, 1981). Second, subjects also saw a role for mental health interventions in dealing with problems caused by stress induced by overwork and discord in the social environment. This suggests that at least some segments of Chinese society are beginning to see a role for mental health professionals in helping to overcome problems associated with psychosocial stressors.

The 'Family Problems' Causal Factor correlated positively with three Help-seeking Factors. The strongest correlation was with the 'Supernatural/folk' Help-seeking Factor. Weaker, but statistically significant correlations, were also found between the 'Family Problems' and the 'Social support (family-friend)' and Traditional/Western

medical Help-seeking Factors. While it makes intuitive sense that individuals experiencing family problems would seek the counsel of other family members and friends, and/or trusted medical practitioners, it is less clear why the this Causal Factor was most strongly associated with Supernatural/folk sources of help. It is possible that helping resources subsumed within this category (e.g., temple/priest, barefoot doctor, etc.) provide advice giving or mediating functions in some Chinese communities (particularly in rural settings).

Also subsumed within the 'Supernatural/folk' Help-seeking Factor is the item 'do nothing and hope the problem goes away'. Thus, another possible explanation for the strength of this association is that not seeking outside (or any) form of intervention may be viewed as the most effective way to deal with family problems. This is consistent with the Chinese tendency to 'not air dirty laundry' with non-family members.

It was also notable that the 'Family Problems' Causal Factor was most weakly correlated with the Mental health professional Help-seeking Factor. This suggests that subjects viewed mental health interventions as having little relevance to problems originating within the family. Since psychology (and to a lesser extent psychiatry) is still in its infancy as a helping profession in China, it is not surprising that Chinese subjects do not recognise the wider role of the discipline in dealing with dysfunction in the family.

As with the 'Family Problems' Causal Factor, the 'Lacks Inner Resources' Causal Factor correlated most strongly with the 'Social support – self-help' Help-seeking Factor. Thus, individuals who are perceived as suffering from constitutional deficiencies or deficits due to weak or non-existent religious or philosophical beliefs would be expected to seek help from those closest to them. Similarly, undertaking self-

improvement or enrichment activities associated with the 'self-help' concept are seen as most helpful in compensating for the problems inherent in this Causal Factor.

The 'Lacks Inner Resources' Causal Factor was also significantly, but less strongly, correlated with the 'Mental health professional' Help-seeking Factor. Two explanations may account for this correlation. First, it is possible that subjects saw a remediation role for mental health professionals in such 'characterological' deficiencies. Second, it may have been that subjects viewed mental health intervention as useful in a palliative sense, perhaps by enhancing depression coping strategies rather than affecting change at, for example, the level of personality restructuring.

Perhaps most interesting with respect to the 'Lacks Inner Resources' Causal Factor was its low and negative correlation with the Supernatural/folk Help-seeking Factor. While there is no clear conceptual link between a problem such as lacking willpower and supernatural or folk interventions, at an intuitive level, at least, one may expect that visiting a temple or a priest would be perceived as helpful in bolstering a lack of spiritual beliefs. This finding is consistent with that discussed earlier, that members of the focus groups defined the 'lacks spiritual beliefs' item more in terms of philosophical than religious beliefs.

The Negative-depressing influences Causal Factor did not correlate strongly with any of the Help-seeking Factors. The strongest relationship was between this Causal Factor and the Traditional/Western medical Help-seeking Factor. One possible explanation could be that subjects perceived the influence of these medical practitioners as helpful in informing persons so afflicted about the impact of such negative influences on their own mental health. However, since the items that made up this Causal Factor suggest an element of personal choice (e.g., the choice to associate with depressed people or to

prefer books, songs and/or television programs with depressing themes), it may be that subjects' ratings reflect a sense that nothing but the individual her/himself could counter these depressogenic influences.

As a cause of depression, 'Unfulfilled Aspirations' correlated significantly with only the 'Social support/self-help' Help-seeking Factor. It is notable that this is the only Causal Factor to show just one significant correlation with any of the Help-seeking Factors. Again, several explanations are possible here. On one hand, it is possible that subjects viewed the support of family and friends as the only recourse for individuals who may be depressed because of failure to achieve an expected or desired status in life. This may be associated with the strong propensity within Chinese families to exert pressure on their members to achieve higher and higher stations in life (for things such as current material enrichment and for the maintenance or enhancement of the 'family name'). Thus, if the family was the source of the pressure to succeed only they could reduce or eliminate the pressure. On the other hand, family support and friendship may have been perceived as providing solace to people depressed over thwarted aspirations. Finally, it may be that subjects believed that individuals experiencing depression because of unfulfilled aspirations could resort to personal enrichment (self-help) either to improve their station in life or to provide distraction in default of unattainable goals.

Next to the Biological-fatalistic Causal Factor, the Poor Lifestyle Causal Factor showed some of the strongest correlations with Help-seeking Factors. It correlated most strongly with the Traditional/Western medical Help-seeking Factor and the Supernatural/folk Help-seeking Factor. In this regard, it would seem logical that individuals endorsing the Poor health or low resistance component of this Causal Factor would also endorse either Traditional Chinese or Western biomedical interventions.

Impact of Clinical Status and Depression

It was clear that the level of depressive symptoms and clinical status were associated with differences in scores on the various Causal Factors and Help-seeking Factors. The problem that this raises is that future research must take into account both of these factors when measuring such beliefs and preferences. If depressed individuals or individuals with experience in mental health settings give substantially different responses to questions germane to the treatment of their disorder, this throws the entire research enterprise with non-depressed individuals into question. Generalisations about the possible help seeking behaviour of depressed people cannot be made from research that employs non-depressed samples alone. Similarly, predictions of where first-episode patients will go for help cannot be made from studies of studies of clinical populations alone. Cheung (1987) found that the type of setting in which a patient presented had a significant impact on the conceptualisation of their disorder and on the symptoms they disclosed initially in seeking help.

The current research found similar results. Subjects who had high levels of depressive symptoms and those who had experience in the mental health system showed a marked preference for biological causality. On the other hand, persons without such experience rated psychosocial causes more highly. Compared to non-patients, people who were current inpatients or outpatients being treated for depression, showed a marked preference toward mental health professionals and placed less faith in social support or self-help and vice versa.

Examination of Factor Structures

It is notable that the current study revealed factor structures for the causal attributions that were more consistent with those found in studies of Western subjects than in those of Chinese subjects. Two comparisons will be discussed to illustrate this point.

The factor structure found in the current study is perhaps closest to that derived by Norcrosss, Prochaska and Hambrecht (1985) in their study of causal attributions in a U.S. sample. The current study revealed a seven-factor structure using 26 causes whereas the Norcross et al study found ten factors derived from 60 causes[34]. The current study's Biological – fatalistic factor included content consistent with that found in three of Norcross et al's factors labelled: Spiritual determinism, Bad luck and Biological inadequacies. The current Environmental Stress - Downtrodden factor subsumed content comparable to that found in two of Norcross et al's factors labelled: Interpersonal conflict and Environmental difficulties. This suggests that while the U.S. subjects included similar content they differentiated these causal influences along more discrete lines than was the case for the current Chinese sample.

The current 'Family Problems' factor contained content similar to that found in Norcross et al's Family conflicts factor. Finally, the current 'Lacks Inner Resources' factor contained similar content to that of Norcross et al's Insufficient effort factor. This suggests that there are clearly analogous underlying causal dimensions that are parsed in a similar fashion in both cultures.

By contrast, Norcross et al's study revealed several factors for which there are no equivalents in the current findings. These factors were labelled: Maladaptive cognitions,

Chosen lifestyle and Intrapersonal conflicts. Similarly, the current research revealed three factors for which the Norcross et al study contained no equivalents. These were the Negative – depressing influences, the Unfulfilled Aspirations and the Poor Health/Environment factors. This result suggests that there is a set of causal factors that is unique to U.S. culture and another set that is unique to Chinese culture.

Paradoxically perhaps, the factor structure derived in the current study was least similar to that uncovered by Luk and Bond (1992) in their study of Chinese subjects in Hong Kong. In that study, the causal attributions resolved into only two factors labelled the Environmental/heredity factor and the Social-personal factor.

It is important to note here that the Norcross et al (1985) study used a sample of undergraduate students. On the other hand, the Luk and Bond (1992) study employed both undergraduate students and non-student lay people in their study. Further, the Norcross et al's subjects were asked to rate each attribution as it related to a personal problem of their own choosing. Luk and Bond's subjects rated causal attributions as they related to ten clearly defined psychological or social problems. Finally, as mentioned, the Norcross et al study employed a larger and different set of causal attributions, whereas the Luk and Bond study used a set of causal attributions that were very similar to those used in the current study. Thus, while the sample, the problems and the causal attributions used in the Norcross et al study differed widely from those in the current study, there was a greater similarity between the factor structures than between that found in the current study and the Luk and Bond study that employed a

---

[34] Norcross et al originally began with 92 items in their scale but discarded 32 due to inadequate or complex factor loadings on these items.

much more similar sample, clearer problem definitions and a nearly identical set of causal attributions.

Overall, this result suggests several things. First, it suggests that there are certain core causal dimensions that seem to cross cultural lines in the case of the Norcross et al (1985) comparison. However, there is also a set of causal dimensions that are unique to the cultures studied in that research and the current study. Second, this comparison reveals that the different cultures defined causality for psychological problems in broader or finer categories. That the factor structure found in the US study was more similar to that found in the current research than the factor structure found in the Hong Kong study also suggests that there may be greater variation within cultures (in this case Beijing Chinese versus Hong Kong Chinese) than exists across cultures (American versus Beijing Chinese).

Strengths, Weaknesses, and Limitations of the Study

A major strength of the current study is the large and heterogeneous sample used. This sample consisted of Chinese from every walk of life and varied significantly with respect to the main variables in the study (i.e., professional versus lay people, levels of depressive symptoms and clinical status). This sample was also very heterogeneous with respect to many other variables (age, education, locale of residence and birth, etc.). Space limitations and the intent of the current dissertation precluded a full exploration of the impact of these variables. However, these influences will be explored in separate publications.

Another substantial strength of the current research is its use of a combination of etic and emic approaches to scale development and analysis, and the use of a locally derived

and validated instrument (the Chinese Depression Inventory) to measure one of the key variables (level of depression). This allowed for valid statements to be made about the causal beliefs and help seeking preferences of the specific population under examination (the emic component). However, it also allows for more valid comparisons to be made with findings in other cultures (the etic component).

Finally, the current questionnaires combined empirical and phenomenological question formats (rating scales and open ended questions). This approach has the advantage of providing an exhaustive exploration of causal attributions, help seeking preferences and of the treatment of depression in China. This will allow a future analyses to ask questions of the current data set that would otherwise be impossible, and will allow a greater breadth and depth of answers.

Bias Associated with Survey Research Designs

As with any survey research design, there is the potential for demand characteristics, social desirability factors and questionable response sets to bias the data. In as much as it was possible, these confounds were controlled for in the design, administration and data entry phases of the research.

In the data entry phase, data from questionnaires with obvious invalid response sets (e.g., responses that formed diagonal lines or other patterns, or all zero/all four responses, etc.), or questionnaires in which one or more entire scales were omitted, were not entered. However, there were few such questionnaires received.

On the covering letter of the questionnaire the name of the sponsoring department (psychology) of the study was noted as an acknowledgement for their support. However, volunteers were instructed that, if asked prior to collection of the

questionnaires, they were to tell subjects that this was a survey about 'health'. In these ways it was hoped that subjects would be less likely to be cued to the nature and purpose of the study, thus, minimising the likelihood that they would respond in ways they believed would be desirable in a *psychological* study of *depression.*

However, as mentioned earlier, during post-administration debriefings several subjects indicated that they could guess at of the nature and purpose of the study. This is inevitable, and harkens back to the words of Cronbach (1947) cited earlier in regard to test-retest reliability. This quotation bears repeating in the context of the current discussion: "Successive measurements of psychological quantities are rarely independent ... because the act of measurement may change the quantity [measured]" (p.2).

It was believed that guaranteeing anonymity and by inviting subjects to complete the protocols in the privacy of their own homes and to return them in an unmarked sealed envelope would minimise such demand characteristics as social desirability. Low literacy subjects and some of the clinical subjects completed the questionnaire with the assistance of a research assistant or clinician. While every attempt was made to minimise demand characteristics in the study, individual reactions to participation in such a study are inevitable and can only be mentioned as a confounding factor.

The Design of the Questionnaire

It was intended that subjects be kept as naive as possible regarding the nature of the study. However, as mentioned earlier, in acknowledging the contribution of the psychology department to the research on the questionnaire cover sheet, it is possible that this resulted in a bias toward psychologists as a desirable helping resource. It was found that there were significant differences in ratings of psychologist based on various factors (e.g., education). However, the possibility remains that this information could

have had such a biasing effect. The fact that there were differences in the endorsement of psychologist across various different demographic and regional groups may only indicate that this biasing effect differentially impacted groups' endorsements. Therefore, future research may benefit from the omission of such potentially biasing information.

A note regarding the design of the questionnaire and instructions to volunteers is important. Since the current research employed multiple sub-samples and included vignettes in which the stimulus character was either male or female, it was necessary to include a coding system to define these variables for data entry purposes. In the upper right corner of the cover page, therefore, a code was inserted (Mal = male stimulus character and Fem = female stimulus character). In retrospect this code should have been indicated in a less obvious fashion. The problem, fortunately, was caught early in the data gathering phase when it was discovered that volunteers were handing the Mal coded questionnaires to male subjects and the Fem coded questionnaires to female subjects assuming that was the purpose of this code. Only ten questionnaires were distributed in this way and all volunteers were subsequently instructed to distribute the questionnaires without regard to the subjects' gender.

Limitations Associated with the Overall Sample

The sampling procedure inevitably excluded large sectors of the population of Chinese in the People's Republic of China. Indeed, since the research was conducted in the region of only one city, the sample could not reflect the wide range of regional variations that exist in such a culturally diverse nation as the People's Republic of China. As a result, the sample was not truly representative of the Chinese population, and generalisations beyond the population under study must be made with caution. While this does not represent a major threat in the context of the present exploratory

study, in scientific terms it remains a threat to external validity and generalisability. However, every effort was made to make the sample as heterogeneous as possible with respect to variables in the study that may have an impact on causal beliefs and/or help seeking preferences, such as age, level of education, level of depressive symptoms, clinical status, professional status, etc.

Self-selection

The selection of subjects based on voluntary participation introduces a 'self-selection' bias in the sense that those who agree to participate in the study may differ systematically in some respect from those who do not agree to participate in the study. Since it is not valid or ethical to compel participation in research with human subjects, this was unavoidable and can only be acknowledged as a limitation.

Variations in Symptom Severity of the Clinical Sample

Similarly, the sample, in particular the clinical subjects, may have been biased in favour of those who are suffering less severe depression. The reason is that it is likely that a number of those who received a diagnosis of Major Depressive Disorder may have been too ill, or for other reasons, unwilling to participate. Again, since it is not possible, ethical or desirable to compel participation in these cases, this limitation can only be acknowledged.

Limitations associated with the professional sample

As mentioned, the professional sub-sample was relatively small and this limited the types of analyses that could be carried out on the data as well as the conclusions that could be validly drawn from these data. In addition, with the exception of a small group of rural practitioners, the majority came from large Beijing institutions. Many of these

practitioners are exposed to models of psychosocial causality and rehabilitation to a greater extent than the average physician practicing in China. Therefore, it is possible that the psychosocial causal model endorsed by this sample is not representative of the model of causality held the majority of physicians in China. In this context, however, it must be remembered that much of the other research that has been conducted in China finding a biomedical bias among clinicians has involved psychiatric disorders with more dramatic and/or florid presentations such as neurasthenia (e.g., Kleinman, 1982), schizophrenia and bipolar disorder (e.g., Pearson, 1993). Further, these investigations were carried out primarily at psychiatric facilities, which by and large, serve patient populations suffering from disorders such as schizophrenia, bipolar disorder and psychotic depression. Therefore, it is possible that the clinicians in the current study were responding to the nature of the disorder (i.e., major depressive disorder) in their attributions of causality. However, this is an important limitation and should be assessed in future research comparing the ratings that Chinese clinicians would assign to causes for other disorders (e.g., a comparison between causal models for schizophrenia and for depression).

Overlap/Ambiguity Between Depression and Neurasthenia

It was not the purpose of this study to examine disorders other than depression. There is a possibility that the selection criteria for clinical subjects (i.e., only subjects diagnosed with depression) limited this sample to those depressed patients displaying fewer vegetative/somatic symptoms, since individuals emphasising these symptoms may have been diagnosed with neurasthenia. This could have conceivably limited the current sample to patients with less severe depression. Future studies may incorporate a sample of individuals diagnosed with depression and another consisting of neurasthenics.

Low Literacy Subjects

Initially it was intended to administer audio taped protocols to low-literacy subjects (7 or fewer years of formal education). This approach was attempted during the pilot study phase. Both low-literacy and high-literacy subjects indicated that this created confusion and made it difficult to complete the protocols. Therefore, research assistants read the questions aloud to low-literacy subjects (at their request) during the main data-gathering phase. This may have increased demand characteristics and social desirability factors. It was believed that administering the protocols in private would attenuate such biasing. Only the administration to clinical subjects could not be controlled in this way due to limitations in control over the administration conditions in the Chinese hospitals. In the case of the clinical sample, however, only 5 subjects (4% of the clinical sample) reported having 7 or fewer years of formal education.

The Chinese Depression Inventory

The Chinese Depression Inventory (Zheng, & Lin, 1991) was designed to measure depressive symptoms among hospitalised clinically depressed patients. Therefore, its utility for measuring the level of depressive symptoms in non-clinical populations has not been proven. In addition, since it was not possible (due to financial, time, and other constraints) to employ non-self-report measures of depressive symptoms (e.g., the Chinese Hamilton Rating Scale for Depression). Therefore, among subjects of the non-clinical sample, the current study could not answer questions about the instrument's validity for use with this population. In as much as the current research was not intended for this purpose, and that the instrument's validity was tested on clinical populations by its developers (Zheng, & Lin, 1991), it was judged by the author to be acceptable for use in the current study.

Problems Associated with the Vignette

It is possible that the use of vignettes could have biased the results by introducing a non-neutral symptom picture. The presentation of a mixed (psychological and somatic) symptom picture could have influenced the responses of individuals who may have initially held a conceptualisation of depression that substantially favoured one orientation or the other. While it was hoped that the current approach would minimise such biasing effects by providing a balanced symptom constellation, the possibility of such an influence cannot be overlooked.

The Causal Attribution and Help Seeking Preferences Scales

The causal attribution rating scale used had undergone limited testing in terms of its reliability. While the factor structures derived from research in similar populations have been very similar, they have not shown the same consistency when the questionnaire is used across cultures. However, this could reflect actual cultural differences in perceptions of causality for mental disorders.

It was likely that the list of alternatives presented was not exhaustive since many of the 26 items in the causal attribution rating scale and the 16 help seeking preferences scale were borrowed from earlier scales. This could have excluded possible causes and/or help seeking preferences that were relevant in the context of the People's Republic of China. This was remedied to the degree possible by conducting focus groups with three small samples of Chinese subjects to determine if there are any additional attributions or preferences that warranted inclusion. As a result, several modifications were made to the scale. In addition, providing the option for open-ended responses generated other factors perceived by subjects as important causes and help seeking alternatives.

Similarly, some subjects may not have endorsed some help seeking resources due to limited availability of such resources in their community, or they may have been unaware of the existence of some resources that were available. In the former case, this may suggest that such resources need to be made more widely available. The latter case suggests the need for community education programmes to expand such awareness. In either case, this situation was beyond the control of the researcher and impossible to differentiate in the context of the current study.

The Conceptual Approach

The current study examined help seeking preferences from a 'subjective' perspective (i.e., subjects were asked to rate each resource 'as if' they, themselves, were faced with a similar problem to that depicted in the vignette). This required subjects to make a (possibly) counterfactual conceptual leap. In other words, they were asked to imagine that they, themselves, were suffering from depression and to rate the helping resources accordingly. This approach to measuring help seeking preferences may have created difficulty for an individual who had difficulty placing himself or herself in the role of a depressed person.

Some Further Recommendations for Future Research

In addition to addressing some of the shortcomings of the current design listed above, the following are some recommendations for future research.

The current sample was not representative of the wide variety of cultural sub-groups that exist within China. It would be informative to conduct a similar study that sampled (perhaps smaller) groups from various regions of China. In particular, future samples should include a larger proportion of rural residents. Since they constitute the vast

majority of the Chinese population, and are believed to be at higher risk for such problems as depression (see, for example, Phillips, 1998), it is crucial that future research is aimed at a better understanding of their particular mental health beliefs, preferences and needs.

The current vignette was considered to have acceptable face validity as a depiction of 'typical' Chinese depression, by a team of mental health professionals. This team included Chinese psychiatrists and psychologists, as well as Canadian researchers with vast experience in research about Chinese mental health. It would also be informative to conduct a further study of causal beliefs and help seeking preferences using different symptom presentations in the vignette (e.g., contrasting purely psychological, mixed psychological and somatic, and/or a more 'neurasthenic' syndromes).

It would also be interesting and informative to compare these help seeking preferences from both a subjective and an objective perspective (i.e., to contrast how subjects rate helping alternatives for themselves versus how they rate the same alternatives with respect to another person suffering from depression).

Finally, it would be helpful to conduct a longitudinal study that would assess both causal beliefs and help seeking preferences of individuals who have not yet reached the mental health system and contrast these same beliefs and preferences after such experience. This type of study would be difficult and costly since it would require a large enough sample of people to capture those subjects who are subsequently treated formally for depression as inpatients or outpatients. However, this would be the most definitive way possible to sort out the effect of experience with the mental health system on people's causal beliefs and help-seeking preferences.

Summary

The current results suggest that depression and treatment history exert a significant impact on subjects' responses to survey questionnaires such as the one employed in this study. This fact needs to be taken into account in the design of future studies. This is a crucial point for all future research on mental health because it addresses a fundamental aspect of the results; are they valid and applicable to the population of interest. Designing and conducting studies using only university undergraduates is likely to yield little useful information when the results are to be applied to people experiencing significant psychopathologies.

This study showed that Chinese lay and professional people hold causal beliefs that are, for the most part, congruent with those held by their counterparts in the West and by each other. These relatively complex and sophisticated causal theories can loosely be defined as 'psychosocial' in character. It also revealed that Chinese lay people's help-seeking preferences focus on their social support network (family and friends), self-help and mental health professionals (psychologists). This speaks clearly to the necessity of public education such that depressed persons and the family and friends of those suffering from severe depression have more accurate information about the disorder and know where to turn for help when the condition is beyond their capacity to help. While psychology was the most highly rated sources of help in the current study, it remains one of the least available resources in China.

Many authors have referred to the importance of congruence between the explanatory models of the patient and the practitioner (e.g., Norcross, Prochaska, & Hambrecht, 1985; Whittle, 1996). The current research indicated that causal beliefs currently held by health care professionals and lay people are indeed relatively congruent. The difficulty

resides in the fact that aside from mental health specialists, few of the professionals in the current sample had experience treating or knowledge of depression.

There is a very real need to train both more psychologists and to provide training to primary care professionals in China to recognise and treat depression. In addition, there is an urgent need to provide public education about this disorder so that more individuals who are depressed can access necessary and appropriate sources of help in overcoming this disorder.

While it would definitely be helpful to train more primary care health workers in the identification of depression, the problem resides in what to do once depression is diagnosed. One approach to treating identified cases is to offer antidepressant medication. The problem is that for some depressed Chinese patients, pharmacological treatments are prohibitively expensive. A further difficulty with drug intervention alone is the duration of their antidepressant effects.

Earlier studies of the efficacy of cognitive, cognitive behavioural and interpersonal therapies suggest that they are exceedingly effective in treating depression (e.g., Beck, Rush, Shaw, & Emery, 1979; Weissman, Prusoff, DiMascio, Neu, Goklaney, & Klerman, 1979). More recent research suggests that these therapies in combination with pharmacotherapy enhance and extend the antidepressant effect, and significantly reduce the occurrence of relapse (e.g., Paykel et al, 1999).

Kleinman's words bear repeating in this context "although antidepressant drugs may have significantly benefited symptoms, they frequently did not have a major effect on illness problems. ... This ... demonstrates that medical treatment without significant

psychosocial intervention exerts only a limited effect on the overall sickness" (1982, p. 164).

A more sophisticated stance needs to be taken toward targeting interventions at depression. For those in the community who have no resort to or experience with the mental health system, there is a need to provide public education. This should focus on demystifying depression and informing the Chinese public about the manifestations and realities of the disorder. In addition, there is a need to inform the Chinese public that there are effective ways to overcome the disorder.

We also need to consider how we intervene in depression through more culturally sensitive and appropriate therapies. While professional and lay people may hold similar *psychosocial* causal models of depression, this still does not suggest that mainstream health care professionals have appropriate strategies to intervene in depression from a psychosocial perspective. It is incumbent on mental health workers, educators and researchers to lead the way in making culturally sensitive adjustments to existing therapies where possible and to derive perhaps entirely new approaches for sub-populations for whom traditional treatments are ineffective. In the context of the very limited resources of the Chinese mental health community, this may require the adaptation of some of the 'brief' psychotherapies combined with pharmacotherapy to treat acute cases. This type of approach has the advantage of rapid amelioration of symptoms and could be combined with longer-term supportive therapies to minimise relapse rates. It is also likely that family interventions and a greater emphasis on community rehabilitation may help to manage the problems presented by depression.

There is also the problem of depression diagnosed as neurasthenia. Those who invest themselves heavily in the belief that their disorder is purely somatic in nature and origin

do not do well with 'talk therapies' aimed at overcoming psychological difficulties. As Kleinman (1986) showed, such individuals will hold doggedly to this somatic conceptualisation of their disorder. If pharmacological therapies are not practical due to cost or other impediments (e.g., intolerance of side effects), it may be helpful to invoke somato-psychic or body-mind conceptualisations and approaches to treating depression such as those found in various forms of hypnosis (Yapko, 1992).

All of these factors complicate the treatment of depression in China. Much literature in cross-cultural psychology (e.g., Sue, Fujino, et al. 1991; Wong & Piran, 1995) has addressed the need to make therapeutic interventions culturally sensitive and relevant. The wholesale adoption of therapies successfully applied in other cultures should be avoided. Appropriate adjustments to therapeutic approaches found to be effective in treating depression in other cultures (e.g., cognitive-behavioural approaches), or 'made in China' therapies for depression need to come to the fore.

While the picture painted by the World Health Organization (1996) with respect to depression in China is daunting indeed, the situation is not hopeless. If there is the will among professionals and governmental agencies the task of tackling depression can and will bear fruit. With appropriate methods targeted accurately at depression its effects can be diminished. This will benefit not only individuals suffering from depression and their families, but the Chinese people as a whole in the form of reduced health burden to society. The first step is to recognise there is a problem and then to be impelled to action.

Bibliography

Ad Hoc Committee on Health Research Relating to Future Intervention Options (1996). Summary of Investing in Research and Development. Geneva: World Health Organization.

American Psychiatric Association (1994). Diagnostic and Statistical Manual of Mental Disorders (4th ed.). Washington DC: American Psychiatric Association.

Angel, R., & Thoits, P. (1987). The impact of culture on the cognitive structure of illness. Culture Medicine and Psychiatry, 11, 465-494.

Antaki, C., & Brewin, C. (Eds.) (1982). Attributions and Psychological Change. New York: Academic Press.

Arkoff, A., Thaver, F., & Elkind, L. (1966). Mental health and counseling ideas of Asian and American Students. Journal of Counseling Psychology, 13(2), 219-223.

Backstrom, C. H., & Hursh-César, G. (1981). Survey Research (2nd ed.). New York: John Wiley & Sons.

Bain, B. (1996). Pathways to the Peak of Mount Piaget and Vygotsky: Speaking and Cognizing Monolingually and Bilingually. Rome: Bulzoni Editore.

Barrett, J. E., Barrett, J. A., Oxman, T. E., & Gerber, P. D. (1988). The prevalence of psychiatric disorders in a primary care practice. Archives of General Psychiatry, 45. 583-587.

Beard, G. M. (1869). Neurasthenia or Nervous Exhaustion. Boston Medical and Surgical Journal, 3 (13), 217-220.

Beard, G. M. (1881). American Nervousness: Its causes and Consequences. New York: GP Putnam & Sons.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). Cognitive Therapy of Depression. New York: Guilford.

Beiser, M., & Fleming, J. A. E. (1986). Measuring psychiatric disorders among Southeast Asian refugees. Psychological Medicine, 16, 627-639.

Blowers, G. H. (1996). The prospects of a Chinese psychology. In M. H. Bond (Ed.), The Handbook of Chinese Psychology. Hong Kong: Oxford University Press, (pp. 1-14).

Brems, C. (1995). Women and depression: A comprehensive analysis. In E. Edward Beckham, & William R. Leber (Eds.) Handbook of Depression (2nd ed.) New York: Guilford Press. (pp. 539-566).

Brown, G. W. (1993). Life events and affective disorder: replications and limitations. Psychosomatic Medicine, 55, 248-259.

Brown, T., Stein, K., Huang, K., & Harris, D. (1973). Mental illness and the role of mental health facilities in Chinatown. In S. Sue, & N. Wagner (Eds.) Asian Americans: Psychological Perspectives. (pp. 212-231). Palo Alto: Science and Behavior Books.

Caro, I, Miralles, A., & Rippere, V. (1983). What's the thing to do when you're feeling depressed? A cross-cultural replication. Behaviour Research and Therapy, 21(5), 477-483.

Cattell, R. B. (1966). The Scree test for number of factors. Multivariate Behavioral Research, 1, 245-276.

Chan, D. W. (1991). The Beck Depression Inventory: What difference does the Chinese version make? Psychological Assessment, 3(4), 616-622.

Chen, H. S. (1995). Development of mental health systems and care in China: from the 1940's through the 1980's. In W. S. Tseng, T. Y. Lin, & E. K. Yeh (Eds.), Chinese Society and Mental Health. Hong Kong: Oxford University Press.

Cheung, F. M. (1984). Preferences in help seeking among Chinese students. Culture, Medicine and Psychiatry, 8, 371-380.

Cheung, F. M. (1986a). An overview of psychopathology in Hong Kong. In Wen Shing Tseng, & David Y. H. Wu (Eds.), Chinese Culture and Mental Health. Orlando: Academic Press.

Cheung, F. M. (1986b). Psychopathology among the Chinese people. In M. H. Bond (Ed.) The Psychology of the Chinese People. Hong Kong: Oxford University Press.

Cheung, F. M. (1987). Conceptualization of psychiatric illness and help seeking behavior among Chinese. Culture Medicine and Psychiatry, 11, 97-106.

Cheung, F. M., & Lau, B. W. K. (1982). Situational variations of help seeking behavior among Chinese patients. Comprehensive Psychiatry, 23(3), 252-262.

Cheung, F. M., Lau, B. W. K., & Wong, S. W. (1984). Paths to psychiatric care in Hong Kong. Culture, Medicine and Psychiatry, 8, 207-228.

Cheung, F. M., Lee, S. Y., & Chan, Y. Y. (1983). Variations in problem conceptualization and intended solutions among Hong Kong students. Culture, Medicine and Psychiatry, 7, 263-278.

Cheung, P. (1991). Adult psychiatric epidemiology in China in the 80s. Culture, Medicine and Psychiatry, 15(4), 479-496.

Chinese Medical Association, & Nanjing Medical University (1995). Chinese Classification of Mental Disorders (2nd ed, revised) (CCMD-2-R), Nanjing: Dong Nan University Press.

Christensen, C. P. (1987). The perceived problems and help seeking preferences of Chinese immigrants in Montreal. Canadian Journal of Counselling, 21(4), 189-199.

Comrey, A. L., & Lee, H. B. (1992). A first course in factor analysis. Hillsdale, NJ: Erlbaum.

Cooper, J. E., & Sartorius, N. (1996). Mental Disorders in China: Results of the National Epidemiological Survey in 12 Areas. London: Gaskell.

Croll, E. (1997, Spring) China's rural-urban mobility (part 1). China Review,(6), 22-26.

Cronbach, L. J. (1947). Test "reliability": its meaning and determination. Psychometirka, 12, 1-16.

Depression: An overview of the literature (1995). Ottawa: Canadian Mental Health Association.

Dohrenwend, B. S., & Dohrenwend, B. P. (Eds.) (1974). Stressful Life Events: Their Nature and Effects. New York: Wiley.

Draguns, J. G. (1996). Abnormal behaviour in Chinese societies: Clinical, epidemiological, and comparative studies. In M. H. Bond (Ed.), The Handbook of Chinese Psychology. Hong Kong: Oxford University Press, (pp. 412-428).

Durkheim, E. (1951). Suicide (G. Simpson, Trans.). New York: Free Press. (Original work published 1897)

Fabrega, H. (1989). Cultural relativism and psychiatric illness. Journal of Nervous and Mental Disorders, 177(7), 415-425.

Firth J. and Brewin C. (1982). Attributions and recovery from depression: a preliminary study using cross-lagged correlation analysis. British Journal of Clinical Psychology, 21(Pt 3):229-230.

Formanek, R. (1987). Depression and menopause. In R. Formanek, & A. Gurian (Eds.), Women and Depression: A Lifespan Perspective. New York: Springer.

Foulks, E. F., Persons, J. B., & Merkel, R. L. (1986). The effect of patients' beliefs about their illness on compliance in psychotherapy. American Journal of Psychiatry, 143(3), 340-344.

Frank, J. D. (1961). Persuasion and Healing; a Comparative Study of Psychotherapy. Baltimore: The Johns Hopkins Press.

Fugita, S. S., & Crittenden, K. S. (1990). Towards culture- and population-specific norms for self-reported depressive symptomatology. The International Journal of Social Psychiatry, 83(2), 83-92.

Furnham, A. (1989). Overcoming "Psychosomatic" illness: Lay attributions of cure for five possible psychosomatic illnesses. Social Science and Medicine, 29(1), 61-67.

Furnham, A., & Henley, S. (1988). Lay beliefs about overcoming psychological problems. Journal of Social and Clinical Psychology, 6(3/4), 423-438.

Furnham, A., & Kuyken, W. (1991). Lay theories of depression. Journal of Social Behavior & Personality, 6(2), 329-342.

Furnham, A., & Malik, R. (1994). Cross-cultural beliefs about depression. The International Journal of Social Psychiatry, 40(2), 106-123.

Furnham, A., & Rees, J. (1988). Lay theories of schizophrenia. International Journal of Social Psychiatry, 34(3), 212-220.

Greenberg, P. E., Stiglin, L. E., Finkelstein, S. N., & Berndt, E. R. (1993). Depression: A neglected major illness. Journal of Clinical Psychiatry, 54(11) 419-424.

Hall, L. E., & Tucker, C. M. (1985). Relationships between ethnicity, conceptions of mental illness, and attitudes associated with seeking psychological help. Psychological Reports, 57, 907-916.

Hambrecht, M., & Hohmann, M. (1993). Causal attributions in psychiatric patients. European Archives of Psychiatry and Clinical Neuroscience, 242, 318-320.

Havenaar, J. M. (1990). Psychotherapy: Healing by culture. Psychotherapy and Psychosomatics, 53, 8-13.

Henley, S., & Furnham, A. (1988). The attribution of cure. British Journal of Clinical Psychology, 27, 384-386.

Ho, D. Y. F., Spinks, J. A., & Yeung, C. S. H. (Eds.) (1989). Chinese Patterns of Behavior: A Sourcebook of Psychological and Psychiatric Studies. New York: Praeger.

Horowitz, A. (1977). The pathways into psychiatric treatment: Some differences between men and women. Journal of Health and Social Behavior, 18, 169-178.

Jack, R. L., & Williams, J. M. G. (1991). Attribution and intervention in self poisoning. British Journal of Medical Psychology, 64, 345-358.

Kaelber, C. T., Moul, D. E., & Farmer, M. E. (1995). Epidemiology of depression. In E. Edward Beckham, & William R. Leber (Eds.) Handbook of Depression (2nd ed.) New York: Guilford Press. (pp. 3-35).

Kamerow, D. B. (1988). Anxiety and depression in the medical setting: an overview. The Medical Clinics of North America, 72. 745-751.

Kessler, R. C., McGonagle, K. A., Swartz, M., Blazer, D. G., & Nelson, C. B. (1993). Sex and depression in the National Comorbidity Survey: I. Lifetime prevalence, chronicity and recurrence. Journal of Affective Disorders, 29, 85-96.

Kind, P., & Sorenson, J. (1993). The costs of depression. Third International Symposium: RIMAs in subtypes of depression: Focus on moclobemide (1992, Vienna, Austria). International Clinical Psychopharmacology, 7(3-4) 191-195. Abstract from: DIALOG File: PsychINFO Item: 80-30726.

Kleinman, A. (1975). The symbolic context of Chinese medicine. A comparative approach to the study of traditional medical and psychiatric forms of care in Chinese culture. American Journal of Chinese Medicine, 3, 103-124.

Kleinman, A. (1977). Depression, somatisation and the new 'cross-cultural psychiatry'. Social Science and Medicine, 11, 3-10.

Kleinman, A. (1982). Neurasthenia and depression: A study of somatization and culture in China. Culture,-Medicine-and-Psychiatry, 6(2) 117-190.

Kleinman, A. (1986). Social Origins of Distress and Disease: Depression, Neurasthenia and Pain in Modern China. New Haven: Yale University Press.

Kleinman, A. (1988). A window on mental health in China. American Scientist, 76(1), 22-27.

Kleinman, A. M. (1980). Patients and Healers in the Context of Culture: An Exploration of the Borderland Between Anthropology, Medicine and Psychiatry. Berkeley: University of California Press.

Kleinman, A., & Good, B. (Eds.) (1985). Culture and Depression: Studies in the Anthropology and Cross-Cultural Psychiatry of Affect and Disorder. Berkeley: University of California Press.

Knapp, J. R., & Delprato, D. J. (1980). Willpower, behavior therapy, and the public. The Psychological Record, 30. 477-482.

Knapp, J. R., & Karabenick, S. A. (1985). Overcoming problems: The perceived importance of willpower and other contributors. Cognitive Therapy and Research, 9(3), 343-354.

Kroeber, A. L., & Kluckhohn, C. (1963). Culture: A Critical Review of Concepts and Definitions. New York: Vintage.

Kulka, R. A., Veroff, J., & Douvan (1979). Social class and the use of professional help for personal problems: 1957 and 1976. Journal of Health and Social Behavior, 20, 2-17.

Kuo, W. H. (1984). Prevalence of depression among Asian-Americans. The Journal of Nervous and Mental Disease, 172(8), 449-457.

Kuyken, W., Brewin, C. R., Power, M. J., & Furnham, A. (1992). Causal beliefs about depression in depressed patients, clinical psychologists and lay persons. British Journal of Medical Psychology, 65, 257-268.

Lambert, M. J. (1992). Psychotherapy outcome research: Implications for integrative and eclectic therapists. In J. C. Norcross, & M. R. Goldfried (Eds.), Handbook of Psychotherapy Integration. New York: Basic Books.

Langner, T. S. (1962). A twenty-two item screening score of psychiatric symptoms indicating impairment. Journal of Health and Human Behavior, 3, 269-276.

Lee, L. C. (1998). An Overview. In L. C. Lee & N. W. S. Zane (Eds.), Handbook of Asian American Psychology (pp. 1-20). Thousand Oaks CA: Sage.

Lee, R. N. F. (1986). The Chinese perceptions of mental illness in the Canadian mosaic. Canada's Mental Health, 34(4), 2-4.

Lee, S. (1996). Cultures in psychiatric nosology: the CCMD-2-R and international classification of mental disorders. Culture, Medicine and Psychiatry, 20, 421-472.

Li, G. H., & Baker, S. P. (1991). A comparison of injury death rates in China and the United States. American Journal of Public Health, 81, 605-609.

Li, S., & Phillips, M. R. (1990). Witch doctors and mental illness in Mainland China: A preliminary study. American Journal of Psychiatry, 147(2), 221-224.

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. Dordrecht Netherlands: D. Reidel.

Lin, K. M., Inui, T. S., Kleinman, A. M., & Womack, W. M. (1982). Sociocultural determinants of the help seeking of patients with mental illness. The Journal of Nervous and Mental Disease, 170(2), 78-85.

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

and T. Y. Lin (Eds.), Normal and Abnormal Behaviour in Chinese Cultures. (pp. 237-272). Dordrecht, Netherlands: D. Reidel.

Lin, N., & Ensel, W. M. (1984). Depression mobility and its social etiology: The role of life events and social support. Journal of Health and Social Behavior, 25, 176-188.

Lin, T. Y. (1989). Neurasthenia revisited: its place in modern psychiatry. Culture, Medicine, and Psychiatry, 13(2), 105-129.

Lin, T. Y., Rin, H., Yeh, E. K., Hsu, C. C., & Chu, H. (1969). Mental disorders in Taiwan fifteen years later: A preliminary report. In W. Caudill and T. Lin Mental Health Research in Asia and the Pacific, (pp. 66-91). Honolulu: East-West Center Press.

Lin, T. Y., Tardiff, K., Donetz, G., & Goresky, W. (1978). Ethnicity and patterns of help- seeking. Culture, Medicine and Psychiatry, 2, 3-13.

Linton, R. (1945). The cultural Background of personality. New York: Appelton-Century-Crifts.

Liu, S. X. (1989). Neurasthenia in China: modern and traditional criteria for its diagnosis. Culture, Medicine, and Psychiatry, 13(2), 163-186.

Luk, C. L., & Bond, M. H. (1992). Chinese lay beliefs about the causes and cures of psychological problems. Journal of Social and Clinical Psychology, 11(2), 140-157.

Marsella, A. J. (1980). Depressive experience and disorder across cultures. In H. Triandis & J. Draguns (Eds.) Handbook of Cross-Cultural Psychology: Volume 6 Psychopathology. pp. 237-290. Boston: Allyn & Bacon.

Marsella, A. J. (1982). Culture and Mental Health: An Overview. In A. J. Marsella & G. M. White (Eds.), Cultural Conceptions of Mental Health and Therapy (pp. 359-388). Dordrecht, Holland: Reidel.

Marsella, A. J. (1988). Cross-Cultural research on severe mental disorders: issues and findings. In B. Jansson, & C. Perris (Eds.). Berzelius Symposium XI: Transcultural Psychiatry, Stockholm, Sweden, April 8-10, 1987. Acta Psychiatrica Scandinavica, 78(Suppl. 344), p. 7-22.

Marsella, A. J., Kinzie, J., & Gordon, P. (1973). Ethnocultural variations in the expression of depression. Journal of Cross-Cultural Psychology, 4, 453-458.

Miralles, A., Caro, I., & Rippere, V. (1983). What makes depressed people feel worse? A cross-cultural replication. Behaviour Research and Therapy, 21(5), 485-490.

Murray, J. L., & Lopez, A. D. (Eds.) (1996). The Global Burden of Disease : A Comprehensive Assessment of Mortality and Disability from Diseases, Injuries,

and Risk Factors in 1990 and Projected to 2020. Cambridge, Mass.: Harvard University Press.

Nakane, Y., Ohta, Y., Radford, M., Yan, H., Wang, X., Lee, H. Y., Min, S. K., Michitsuji, S., & Ohtsuka, T. (1991) Comparative study of affective disorders in three Asian countries. II. Differences in prevalence rates and symptoms presentation. Acta Psychiatrica Scandinavica, 84, 313-319.

Nakane, Y., Ohta, Y., Uchino, J., Takada, K., Yan, H. Q., Wang, X. D., Min, S. K., & Lee, H. Y. (1988). Comparative study of affective disorders in three Asian countries. I. Differences in diagnostic classification. Acta Psychiatrica Scandinavica, 78, 698-705.

Narikiyo, T. A., & Kameoka, V. A. (1992). Attributions about mental illness and judgements about help seeking among Japanese-American and White American students. Journal of Counselling Psychology, 39(3), 363-369.

New federal guidelines seek to help primary care providers recognize and treat depression. (1993). News and Notes. Hospital and Community Psychiatry, 44(6), 598.

New, P. K., & Wagson, W. (1983). Pathways to health care among Chinese-Canadians. In P. S. Li, & B. S. Bolaria, Racial Minorities in Multicultural Canada (pp. 56-67). Toronto: Garamond Press.

Norcross, J. C., Prochaska, J. O., & Hambrecht, M. (1985). Levels of Attribution and Change (LAC) scale: Development and Measurement. Cognitive Therapy and Research, 9(6), 631-649.

Nunnally, J. C. (1961). Popular Conceptions of Mental Health: Their Development and Change. New York: Holt, Rinehart & Winston.

Obeysekere, G. (1985). Depression, Buddhism and the work of culture. In A. Kleinman, & B. Good (Eds.), Culture and Depression: Studies in the Anthropology and Cross-Cultural Psychiatry of Affect and Disorder. Berkeley: University of California Press.

Paykel, E. S., Scott J., Teasdale, J. D., Johnson, A. L., Garland, A., Moore, R., Jenaway, A., Cornwall, P. L., Hayhurst, H., Abbott, R., & Pope, M. (1999). Prevention of relapse in residual depression by cognitive therapy: a controlled trial. Archives of General Psychiatry, 56, 829-835.

Pearson, V. (1993). Families in China: An undervalued resource for mental health. Journal of Family Therapy, 15, 163-185.

Pearson, V. (1995). Goods on which one loses: Women and mental health in China. Social Science and Medicine, 41(8), 1159-1173.

Pearson, V. (1999). Words mean what I want them to mean: the analects meet Alice. Transcultural Psychiatry, 36(2), 231-247.

Pearson, V., & Phillips, M. R. (1994). The social context of psychiatric rehabilitation in China. British Journal of Psychiatry, 165 (Suppl. 24), 11-18.

Pedersen, P. B., & Ivey, A. (1993). Culture Centered Counselling and Interviewing Skills: A Practical Guide. Westport, CT: Praeger.

Phillips, M. R. (1998). The transformation of China's mental health services. The China Journal, 39, 1-36.

Phillips, M. R., Liu, H., & Zhang, Y. (1999). Suicide and social change in China. Culture, Medicine & Psychiatry, 23(1), 25-50.

Prochaska, J. O. (1984). Systems of Psychotherapy: A Transtheoretical Approach (2nd ed.). Homewood Ill.: Dorsey Press.

Prochaska, J. O., & DiClemente, C. C. (1984). The Transtheoretical Therapy: Crossing the Traditional Boundaries. Homewood, Ill.: Dow Jones/Irwin.

Psychological Medicine Research Center of the West China University of Medical Sciences (1990). National Listing of the Treatment, Educational, and Research Institutions for Mental Health (in Chinese). Chengdu: Sichuan Psychological Association.

Rin, H., & Huang, M. G. (1989). Neurasthenia as nosological dilemma. Culture, Medicine, and Psychiatry, 13(2), 215-226.

Rippere, A. (1981b). How depressing: another cognitive dimension of commonsense knowledge. Behaviour Research and Therapy, 19, 169-181.

Rippere, V. (1977a). Some cognitive dimensions of antidepressive behaviour. Behaviour Research and Therapy, 15, 57-63.

Rippere, V. (1977b). What's the thing to do when you're feeling depressed? – a pilot study. Behaviour Research and Therapy, 15, 185-191.

Rippere, V. (1977c). Commonsense beliefs about depression and antidepressive behaviour: Behaviour Research and Therapy, 15, 465-473.

Rippere, V. (1979). Scaling the helpfulness of antidepressive activities. Behaviour Research and Therapy, 17, 439-449.

Rippere, V. (1980a). Predicting consensus about propositions concerning depression and antidepressive behaviour: Another dimension of commonsense knowledge. Behaviour Research and Therapy, 18, 79-86.

Rippere, V. (1980b). What makes depressed people feel worse? Behaviour Research and Therapy, 18, 87-97.

Rippere, V. (1980c). Predicting frequency, intensity, and deviation of other people's self-reported depression. Behaviour Research and Therapy, 18, 259-264.

Rippere, V. (1980d). Some historical dimensions of commonsense knowledge about depression and antidepressive behaviour. Behaviour Research and Therapy, 18, 373-385.

Rippere, V. (1981a). The survival of traditional medicine in lay medical man. Medical History, 25, 411-414.

Rummel, R. J. (1970). Applied Factor Analysis. Evanston: Northwestern University Press.

Rupp, A. (1995). The economic consequences of not treating depression. British Journal of Psychiatry, 166(Suppl. 27), 29-33.

Schulberg, H. C., & Burns, B. J. (1988). Mental disorders in primary care: Epidemiologic, diagnostic, and treatment research directions. General Hospital Psychiatry, 10. 79-87.

Serota, C. A. (1987). Demographic and clinical variations in the perception of causality and control among first-episode psychotic patients in Hawaii. Dissertation Abstracts International, 47(12-B, Pt 1), 4837.

Shek, D. T. (1990). Reliability and factorial structure of the Chinese version of the Beck Depression Inventory. Journal of Clinical Psychology, 46(1), 35-43.

Shek, D. T. (1991). What does the Chinese version of the Beck Depression Inventory measure in Chinese students--general psychopathology or depression? Journal of Clinical Psychology, 47(3), 381-390.

Sinclair, D. B. (1994). Mainland Chinese lay beliefs about psychological problems: An examination of beliefs about causes and cures. Unpublished master's thesis, University of Alberta, Edmonton, Alberta, Canada.

Singer, K. (1975). Depressive disorders from a transcultural perspective. Social Science and Medicine, 9(6), 289-301.

Snowden, L. R., & Cheung, F. K. (1990). Use of inpatient mental health services by members of ethnic minority groups. American Psychologist, 45, 347-355.

State Statistical Bureau of the People's Republic of China (1996). China Statistical Yearbook. Beijing: China Statistical Information & Consultancy Service Centre.

Statistics Canada (1996). Health expenditures by type. Health Indicators (computer disk: April, 1996). Cat. 82-221-XDE.

Statistics Canada (1997). Immigrant Population by Place of Birth and Sex, Showing Period of Immigration, for Canada, Provinces, Territories and Census Metropolitan Areas. The Nation : 1996 Census of Population (computer disk: November, 1997). Cat. 93F0023XDB96003.

Stewart, D. E. (1990). The changing faces of somatization. Psychosomatics, 31(2), 153-158.

Styron, W. (1990). Darkness Visible: A Memoir of Madness. New York: Random House.

Sue, D. W., & Kirk, B. A. (1975). Asian-Americans: Use of counseling and psychiatric services on a college campus. Journal of Counseling and Psychology, 22(1), 84-86.

Sue, D. W., & Sue, D. (1977). Barriers to effective cross-cultural counseling. Journal of Counseling Psychology, 24(5), 420-429.

Sue, S. (1977). Community mental health services to minority groups: Some optimism, some pessimism. American Psychologist, 32, 616-624.

Sue, S., & McKinney, H. (1975). Asian Americans in the community mental health care system. American Journal of Orthopsychiatry, 45, 111-118.

Sue, S., & Sue, D. W. (1974). MMPI comparisons between Asian-American and Non-Asian students utilizing a student health psychiatric clinic. Journal of Counseling Psychology, 21(5), 423-427.

Sue, S., Fujino, D. C., Hu, L., Takeuchi, D. T., & Zane, N. W. S. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. Journal of Consulting & Clinical Psychology, 59(4), 533-540.

Sue, S., Wagner, N., Ja, Davis, Margullis, C., & Lew, L. (1976). Conceptions of mental illness among Asian and Caucasian-American students. Psychological Reports, 38, 703-708.

Sussman, L. K., Robins, L. N., & Earls, F. (1987). Treatment-seeking for depression by black and white Americans. Social Science & Medicine, 24(3) 187-196.

Tanaka, J. S., Ebreo, A., Linn, N., & Morera, F. (1998). Research methods: the construct validity of self-identity and its psychological implications. In L. C. Lee & N. W. S. Zane (Eds.), Handbook of Asian American Psychology (pp. 21-82). Thousand Oaks CA: Sage.

Tao, X. (1997). Mental health education reform in China: a revolutionized model. The University of Hong Kong, Robert Black College, 30th Anniversary Jubilee Journal. Hong Kong: University of Hong Kong.

The Complete Acupuncture [CD-Rom] (1997). Hopkins, MN: Hopkins Technology [Producer and Distributor]

Tian, W., Pearson, V., Wang, R., & Phillips, M. R. (1994). A brief history of the development of rehabilitative services in China. British Journal of Psychiatry, 165(suppl. 24), 19-27.

Tracey, T. J., Leong, F. T., & Glidden, C. (1986). Help seeking and problem perception among Asian Americans. Journal of Counseling Psychology, 33(3), 331-336.

Traditional Chinese Medicine and Pharmacology [CD-Rom] (1997). Hopkins, MN: Hopkins Technology [Producer and Distributor]

Ware, N. C., & Kleinman, A. (1992). Culture and somatic experience: the social course of illness in neurasthenia and chronic fatigue syndrome. Psychosomatic Medicine, 54, 546-560.

Ware, N. C., & Kleinman, A. (1992). Depression in neurasthenia and chronic fatigue syndrome. Psychiatric Annals, 22(4), 202-208.

Weiner, B. (1980). Human Motivation. New York: Holt Rinehart and Winston.

Weiner, B. (1985). An attributional theory of achievement motivation and emotion. Psychological Review, 92(4), 548-573.

Weissman, M. M., Bruce, M., Leaf, P., Florio, L., & Holzer, C. (1991). Affective disorders. In L. Robins, & E. Regier (Eds.), Psychiatric Disorders in America, pp. 53-80. New York: Free Press.

Weissman, M. M., Prusoff, B. A., DiMascio, A., Neu, C., Goklaney, M., & Klerman, G. L. (1979) The efficacy of drugs and psychotherapy in the treatment of acute depressive episodes. American Journal of Psychiatry, 136, 555-558.

Wessely, S. (1990). Old wine in new bottles: neurasthenia and 'ME'. Psychological Medicine, 20, 35-53.

Westermeyer, J., & Wintrob, R. (1979). "Folk" explanations of mental illness in rural Laos. American Journal of Psychiatry, 136(7), 901-905.

Whittle, P. (1996). Causal beliefs and acute psychiatric admission. British Journal of Medical Psychology, 69, 335-370.

Wong, O. -N. C., & Piran, N. (1995). Western biases and assumptions as impediments in counselling traditional Chinese clients. Canadian Journal of Counselling, 29(2), 107-119.

World Health Organization (1992). International classification of diseases. 10th revision, Classification of mental and behavioral disorders. Geneva: World Health Organization.

World Health Organization (1992). The ICD-10 Classification of Mental and Behavioural Disorders - Clinical Descriptions and Diagnostic Guidelines. Geneva: W.H.O.

Xu, J. (1991). Clinical application and evaluation of the Beck Depression Inventory. Psychological Science (China),4, 32-34 (in Chinese).

Yan, H. Q. (1989). The necessity of retaining the diagnostic concept of neurasthenia. Culture, Medicine, and Psychiatry, 13(2), 139-146.

Yap, P. M. (1965). Phenomenology of affective disorders in Chinese and other cultures. In A. V. S. DeReuck, & R. Porter (Eds.), Transcultural Psychiatry. Boston: Little and Brown (pp. 86-114).

Yapko, M. D. (1992). Hypnosis and the Treatment of Depression. New York: Brunner/Mazel.

Yi, Xin (1996, June 12). Medical reform to benefit all. China Daily, p. 4.

Ying, Y. W. (1990). Explanatory models of major depression and implications for help seeking among immigrant Chinese-American women. Culture, Medicine and Psychiatry, 14, 393-408.

Ying, Y. W. (1990). Explanatory models of major depression and implications for help seeking among immigrant Chinese-American women. Culture, Medicine and Psychiatry, 14, 393-408.

Ying Y. W., & Miller, L. S. (1992). Help-seeking behavior and attitude of Chinese Americans regarding psychological problems. American Journal of Community Psychology, 20(4), 549-556.

Zheng, Y. P., & Lin, K. M. (1991). Comparison of the Chinese Depression Inventory and the Chinese version of the Beck Depression Inventory. Acta Psychiatrica Scandinavica, 84, 531-536.

Zheng, Y. P., Lin, K. M., Zhao, J. P., Zhang, M. Y., & Young, D. (1994). Comparative study of diagnostic systems: Chinese Classification of Mental Disorders - Second Edition versus DSM-III-R. Comprehensive Psychiatry, 35, 441-449.

Zhou, R. Y., Zhang, Y. H., & Zhu, C. M. (1995). A comparison of the CCMD-2-R and ICD-10 diagnosis of mood disorders using the SCID-P. Journal of Clinical Psychological Medicine, 5, 357-359 (in Chinese).

Appendices

Appendix A

Lay subjects questionnaire (Chinese version)

您所看到的是一份包括三个部分的调查问卷。回答这些问题大约需要20分钟。您先 看到的是一个小故事，在第一和第二部分里，您将回 答有关此故事的问题。在第三 部分里，您将回答关于最近一周您本人的健康状况。该问卷是作为论文研究的一部 分，並且也得到了北京大学心理学系的大力协助和支持。我们对您提供的信息绝对 保密（您不需写下您的姓名、地址等）所以请您一定按照您真实的想法回答每一个 问题，回答此卷时不要与他人商量有关问卷中的答案。当您完成问卷以後请及时交 还我。参加该问卷是以志愿的原则为基础的，所以您可在任何时间放弃参与这项研 究。

非常感谢您的合作。

请填写以下个人资料。所有个人资料绝对保密。请不要在卷中写下您的姓名。

年龄：_____岁

教育年限：_____年

家庭人口：_____人

家庭月收入：_____元

请您在适合的空格上画（__√__）

性别： 男_____ 女 _____

婚姻状况：未婚_ 已婚__ 分居_离婚_其他___

出生地点：城市___乡村___

出生地区：北方___南方___

第一部分

请您仔细认真阅读下面的小故事，并回答下面的问题。

王先生在过去的一年里一直遭受着某些痛苦。在那段时间里，不知怎的他 心里总感 到很忧伤，觉得生活没有意思，对未来也感到没有希望。他很难集中精力把事情做 好，对原先喜欢做的一些事情和爱好也都失去了兴趣。他跟你说，他时常感 到心里 很烦躁，有时会因一件小事竟与别人争吵。他常常入睡很困难，有时清晨四点就醒 了，并再不能入睡。他从来不想减肥使自己变瘦，但他的食欲却一直很差，身体在 最近3个月来减少了9公斤左右。他总觉得全身无力似的，干一点活就感到很疲劳。 他告诉你说，他一直觉得头、颈、胃、腰疼，但在各种医学检查后，医生告诉他没 有检查出什么毛病。他觉得他这些感觉或问题好像在早晨比较重，晚上会稍好一点 。周围人觉得他说话、动作都很慢，而且似乎很费力似的。单位领导考虑到他不能 很好地胜任工作，只能让他休病假了。

请您根据王先生的状况写出一个名称（即此名称能形容王先生的问题）：_____

以下是可能导致王先生患上这问题的原因。请在原因程度表上画出您认为适当的数字（即在适当的数字上圈上一个圆圈，请参照例题）。请回答所有的问题而不要遗漏任何一个，问卷的填写对于本研究至关重要，即使您对任何一个项目不是十分肯定，也8请画出您认为最适当的数字。

填表指导： 这份问卷由26个原因组成，每项均有0--4个数字，分别代表：

0=毫无关系，1=有一点关系，2=比较有关系，3=有关系，4=有很大关系

		原因程度表				
题号	王先生可能患上这问题的原因	毫无关系	有一点关系	比较有关系	有关系	有很大关系
例题	如您认为此原因与王先生出现的问题有很大关系，应在4号 上划圈	0	1	2	3	(4)
1	王先生的问题根源是和先天遗传有关系	0	1	2	3	4
2	他是受过高等教育或者是知识丰富的人	0	1	2	3	4
3	现实生活与他的理想相差太远	0	1	2	3	4
4	这是跟更年期有关系	0	1	2	3	4
5	他失去了生活中最亲密的人	0	1	2	3	4
6	他是不幸运的或者他是命中注定会出现那些问题	0	1	2	3	4
7	他的事业受到了挫折	0	1	2	3	4
8	他的脑部或神经系统出现了问题	0	1	2	3	4
9	他的生活贫困并且生活得不顺心	0	1	2	3	4
10	他不太聪明也没有什麼本事	0	1	2	3	4
11	他成长的经历和常人不同（例如他被养大的方式）	0	1	2	3	4
12	他是受到了电视，报章杂志，小说或广播媒介的影响	0	1	2	3	4
13	他曾经与一些患有同样问题的朋友相处过	0	1	2	3	4
14	夫妻感情出现危机	0	1	2	3	4
15	他工作或学习的环境状况不好	0	1	2	3	4
16	他的工作压力太大	0	1	2	3	4
17	他身体的健康状况不佳而且抵抗能力不强	0	1	2	3	4
18	他受到鬼神的滋扰	0	1	2	3	4
19	他的家庭生活不和睦	0	1	2	3	4
20	他和同学，朋友或同事相处不融洽，人际关系出现危机	0	1	2	3	4
21	他的性格软弱（他不是一个坚强有毅力的人）	0	1	2	3	4
22	他的居住环境很差	0	1	2	3	4
23	是由于细菌或病毒的传染导致他出现那些问题	0	1	2	3	4
24	他的教育程度较低	0	1	2	3	4
25	他的生活习惯和常人不同（例如他的起居饮食和嗜好）	0	1	2	3	4
26	他缺少精神支柱	0	1	2	3	4

您如果认为还有其它原因能导致人出现类似问题，请您写在下面：_____

第二部分

针对王先生的状况，我们列出了16条有关的帮助办法。设想如果您遇到此类问题， 请您在下列各项中评估出适合您个人的数字。

评估指导：0=肯定不 用，1=不太实用，2=可以试试，3=愿意采用，4=肯定采用

题号	有关帮助办法的条例	实用的可能性				
		肯定不用	不太实用	可以试试	愿意采用	肯定采用
例题	如果您认为这是一种能帮助您的最好 办法，应在4号上划圈	0	1	2	3	(4)
1	不作任何努力，希望自己能慢慢有所 好转	0	1	2	3	4
2	采用针灸的办法	0	1	2	3	4
3	找赤脚医生帮助	0	1	2	3	4
4	跟家人倾诉，并请家人帮助	0	1	2	3	4
5	向朋友倾诉，并请朋友帮助	0	1	2	3	4
6	找民间江湖医生	0	1	2	3	4
7	采用吃中草药的办法来帮助	0	1	2	3	4
8	采用按摩理疗的方法	0	1	2	3	4
9	找医务卫生员帮助	0	1	2	3	4
10	去看精神病医生	0	1	2	3	4
11	去看心理学医生	0	1	2	3	4
12	找巫师帮助解决	0	1	2	3	4
13	自己解决（比如：多参加文体活动， 外出旅游等等）	0	1	2	3	4
14	去找中医	0	1	2	3	4
15	用祈祷的办法	0	1	2	3	4
16	找西医帮助	0	1	2	3	4

您如果认为还有其它办法能帮助类似问题，请写在下面：_____

请您在适合的空格上画（__√__）

您是否有过类似王先生所出现的问题？有过_ 没有_

如果有过，您是否找过别人的帮助？找过_ 没有_

如果找过，您找了什麼样的人来解决了您的问题？_____

第三部分

填表指导：这份问卷由20个项目组成，每项均有0到4个数码，

分别代表：0=没有，1=偶尔有，2=有时有，3=经常有，4=总是有

请您根据您最近一周包括今天的感觉，每项圈上一个最适合您的数码。

题号	项	最近一周包括今天：				
		没有	偶尔有	有时有	经常有	总是有
例题	我感到头昏或头晕	0	1	2	3	(4)
1	我真希望自己那天突然死去	0	1	2	3	4
2	小事我也感到十分着急	0	1	2	3	4
3	遇到一点小事，我就感到烦躁	0	1	2	3	4
4	我感到在生活中自己是个弱者	0	1	2	3	4
5	我感到人活着没有什么意思	0	1	2	3	4
6	我感到心慌	0	1	2	3	4
7	对异性我毫无兴趣	0	1	2	3	4
8	我觉得自己太笨，样样不如别人	0	1	2	3	4
9	我变得做什麼事都拿不定主意了	0	1	2	3	4
10	我想自己去死	0	1	2	3	4
11	我全身没有一点力气	0	1	2	3	4
12	我讲话的声音变得有气无力或讲话少多了	0	1	2	3	4
13	我晚上睡眠时间总的来说至少比往常少多了	0	1	2	3	4
14	我什麼事都不想干	0	1	2	3	4
15	我感到不高兴、不愉快、不痛快	0	1	2	3	4
16	我感到心里难受或心里不舒服	0	1	2	3	4
17	我对周围的一切都感到没有意思	0	1	2	3	4
18	我感到紧张不安	0	1	2	3	4
19	我不想吃东西或吃不下饭	0	1	2	3	4
20	我觉得自己比平时瘦多了	0	1	2	3	4

非常感谢您的大力协助

Appendix B

Lay subjects questionnaire (English version)

This questionnaire has three parts that will take about 20 minutes to complete. You will first read story and then be asked to answer two sets of questions about the story. You will then be asked to complete a third set of questions about your health over the last week. The information collected in this questionnaire will be used for a research project that is being conducted with the assistance and encouragement of Beijing University as part of a doctoral dissertation. The information obtained is confidential (we do not record your name, address, etc.) so please complete all of the questions according to what you really believe without consulting other people. Your participation is completely voluntary; you may stop completing the questionnaire at any time.

PLEASE FILL OUT THE FOLLOWING INFORMATION ABOUT YOURSELF

(because the information is confidential do not record your name anywhere in the booklet):

Age ____ years

Years of completed schooling ____ years

Number of persons in nuclear family ____ persons

Average total monthly income to nuclear family ____ yuan

PLEASE PUT A CHECKMARK (√) BESIDE THE APPROPRIATE ITEM:

Gender: Male ____ Female ____

Marital status: Single ____ Married ____ Separated ____ Divorced ____ Other ____

Place of birth (type) Urban ____ Rural ____

Place of birth (region) Northern China ____ Southern China ____

Section One

Below there is a short story, please read it carefully and then read the instructions and answer the questions that follow the story.

Mr. Wang has been experiencing some difficulties for the past three months. He reports that during this period he has been feeling sad for no apparent reason. He tells you that he has been feeling as though his life has no meaning and he feels hopeless about the future. He says that he has lost interest in doing almost everything that he previously enjoyed doing including his hobbies. He has been feeling irritable and sometimes argues with others over small matters. He has become increasingly withdrawn and says he has no desire to visit with friends or family. He reports that he has had difficulty going to sleep at night and that often he wakes in the middle of the night and has difficulty going back to sleep. He says that sometimes he awakens at about four o'clock in the morning and cannot go back to sleep. He tells you that, although he has not been trying to loose weight, his appetite has been poor and that he has lost about 20 pounds in the last three months. He reports that he has been feeling weak all over and has no energy, and that even the slightest exertion leaves him feeling so exhausted so that he frequently has to lay down and rest during the day. He reports that he has had headaches, stomach and back pain but that after many medical tests his doctor says there is nothing physically wrong with him. As a result of his difficulties he has not been able to work and his employer has told him to take sick leave until he gets better.

What would you call the problem that Mr. Wong is experiencing? (What is the name of Mr. Wong's problem) _____

Below are 26 possible causes for Mr. Wang's problems. Circle one number beside each cause to indicate how important you believe each cause is (please see example below). Answer all of the questions without omitting any. The meanings of the ratings are as follows:

0 = Not at all important, 1 = Not very important, 2 = May be important,
3 = Likely important, 4 = Definitely important

		Importance of possible causes				
#	Possible causes of Mr. Wang's problem:	Not at all Important	Not very Important	May be Important	Likely Important	Definitely Important
Ex:	If you believe a cause is "Very important" you would circle the number "4"	0	1	2	3	(4)
1	The problem is caused by his genetic disposition	0	1	2	3	4
2	He is too highly educated or affluent	0	1	2	3	4
3	His actual life status is too far below his expectations	0	1	2	3	4
4	His problem is due to menopause	0	1	2	3	4
5	He has lost someone very close to him	0	1	2	3	4
6	Mr. Wang is unlucky or predestined to have the problem	0	1	2	3	4
7	He has encountered many defeats in life	0	1	2	3	4
8	There is something wrong with Mr. Wang's brain or nervous system	0	1	2	3	4
9	He is too poor and unsatisfied with life	0	1	2	3	4
10	He lacks the intelligence or ability to manage things	0	1	2	3	4
11	His past experience (e.g., upbringing) is different from that of other people	0	1	2	3	4
12	He has been influenced by media (e.g., books, magazines, newspapers, television)	0	1	2	3	4
13	Mr. Wang has had interaction with friends having the same problem	0	1	2	3	4
14	He is experiencing marital problems	0	1	2	3	4
15	The environment in which he works/studies is not good	0	1	2	3	4
16	He has been suffering from a very heavy workload	0	1	2	3	4
17	His state of health and resistance of the body to germs is not good	0	1	2	3	4
18	Mr. Wang is disturbed by supernatural beings	0	1	2	3	4
19	His family life is not harmonious	0	1	2	3	4
20	He is not getting along well with her/his friends and/or colleagues (interpersonal crisis)	0	1	2	3	4
21	Mr. Wang has a soft personality (i.e., he is not a tough person, lacks willpower)	0	1	2	3	4
22	The environment in which Mr. Wang lives is not good	0	1	2	3	4
23	He is infected by bacteria or germs	0	1	2	3	4
24	He lacks formal education	0	1	2	3	4
25	His lifestyle is different from that of other people (e.g., eating habits, sleeping habits, any peculiar habits)	0	1	2	3	4
26	He lacks spiritual beliefs	0	1	2	3	4

Please write down any other causes that you may think of which we have not included in our list but that you believe to be important.

_____

_____

Section Two

Listed below are 16 different sources of help people may seek if they were experiencing a problem like Mr. Wang's. Imagine that you encountered the same kind of problem and please rate your preference for every one of the sources of help. The meanings of the ratings are as follows:

0 = I definitely would not use this type of help, 1 = I would be less likely use this type of help, 2 = I might try this type of help, 3 = I would be more likely to use this type of help, 4 = I definitely would use this type of help

#	Sources of Help	Likelihood of using this type of help				
		Definitely would not	Would be less likely	Might try this type	More likely	Definitely would
Ex	If you thought this was the best type of help you would circle number 4	0	1	2	3	(4)
1	Do nothing, hope it goes away	0	1	2	3	4
2	Acupuncturist	0	1	2	3	4
3	'Barefoot' doctor	0	1	2	3	4
4	Family member	0	1	2	3	4
5	Friend	0	1	2	3	4
6	Folk healer	0	1	2	3	4
7	Herbalist	0	1	2	3	4
8	Massage therapist	0	1	2	3	4
9	Community health nurse	0	1	2	3	4
10	Psychiatrist	0	1	2	3	4
11	Psychologist	0	1	2	3	4
12	Shaman	0	1	2	3	4
13	Self Help (e.g., exercise, self improvement courses)	0	1	2	3	4
14	Traditional Chinese medical doctor	0	1	2	3	4
15	Visit a temple or a priest	0	1	2	3	4
16	Western medical doctor	0	1	2	3	4

Please write down any other types of help that you may think of which we have not included in our list but that you believe to be important.

_____

PLEASE PUT A CHECKMARK (√) BESIDE THE APPROPRIATE ITEM:

Have you ever experienced a problem similar to Mr. Wang's? Yes ____ No ____

If yes, did you get help to overcome the problem? Yes ____ No ____

If yes, what type of person helped you to overcome this problem? _____

Section Three

Instructions: This form has 20 items. For each item there are five alternatives numbered 0 to 4.

The alternatives are: 0 = never, 1 = seldom, 2 = At times, 3 = often, 4 = always

Please select the rating for each item that reflects your feelings during the past week including today.

		During the most recent week including today				
#	Item	Never	Seldom	At times	Often	Always
Ex:	A lot of things bother me	0	1	2	3	(4)
1	I wish I would just die one day	0	1	2	3	4
2	I get very worried even about small things	0	1	2	3	4
3	I get very irritable when over small problems	0	1	2	3	4
4	I feel I am a weak person in life	0	1	2	3	4
5	Life has no meaning for me	0	1	2	3	4
6	I feel nervous and alarmed (panic)	0	1	2	3	4
7	I have no interest in the opposite sex	0	1	2	3	4
8	I feel dumb and inferior to others	0	1	2	3	4
9	When doing anything I feel indecisive (confused)	0	1	2	3	4
10	I would like to kill myself	0	1	2	3	4
11	I have no energy at all	0	1	2	3	4
12	I speak more quietly and talk less than usual	0	1	2	3	4
13	I sleep much less now than usual	0	1	2	3	4
14	I have no desire (motivation) to do anything	0	1	2	3	4
15	I feel unhappy, joyless, dissatisfied	0	1	2	3	4
16	I feel uncomfortable in my heart	0	1	2	3	4
17	I have no interest in things around me (anhedonia)	0	1	2	3	4
18	I feel nervous and anxious	0	1	2	3	4
19	I can't and don't want to eat	0	1	2	3	4
20	I feel my body weight is lower than normal	0	1	2	3	4

Thank you for your participation in this study

Appendix C

Professional subjects questionnaire (Chinese version)

PROM _____

您所看到的是一份包括二个部分的调查问卷。您先看到的是一个小故事，在第一和 第二部分里，您将回答有关此故事的问题。该问卷是作为论文研究的一部分，並且 也得到了北京大学心理学系的大力协助和支持。这个调查问卷主要是想多一点了解 您是怎样帮助类似下面故事里的人，此研究的最终目的是要找到最有效的办法来帮 助出现类似这种问题的人。我们对您提供的信息绝对保密（您不需写下您的姓名、 地址等）所以请您一定按照您真实的想法回答每一个问题。参加该问卷是以志愿的原则为基础的，所以您可在任何时间放弃参与这项研究。

请填写以下个人资料。所有个人资料绝对保密。请不要在卷中写下您的姓名。

年龄：___岁

教育年限：___年

在专业学校念完了几年书：___年

从专业学校毕业的时间（如果有两个文凭，请只用第一个文凭）：___年__月

在本专业的工作年限：_____年

现家庭人口：_____人

家庭月收入：___元

请您在适合的空格上画√_（只限填一个）

专业类型：西医___中医___护士___药技师___

_____针灸师___按摩师___精神科医生____心理专家___

_____其他（请注明专业）：_____

性别：__男___女__

婚姻状况：未婚___已婚___分居___离婚___其他__

出生地点：城市__乡村__

出生地区：北方__南方__

第一部分

请您仔细认真阅读下面的小故事，并回答下面的问题。

王先生在过去的一年里一直遭受着某些痛苦。在那段时间里，不知怎的他心里总感 到很忧伤，觉得生活没有意思，对未来也感到没有希望。他很难集中精力把事情做 好，对原先喜欢做的一些事情和爱好也都失去了兴趣。他跟你说，他时常感到心里 很烦躁，有时会因一件小事竟与别人争吵。他常常入睡很困难，有时清晨四点就醒 了，并再不能入睡。他从来不想减肥使自己变瘦，但他的食欲却一直很差，身体在 最近3个月来减少了9公斤左右。他总觉得全身无力似的，干一点活就感到很疲劳。 他告诉你说，他一 直觉得头、颈、胃、腰疼，但在各种医学检查后，医生告诉他没 有检查出什么毛病。他觉得他这些感觉或问题好像在早晨比较重，晚上会稍好一点 。周围人觉得他说话、动作都很慢，而且似乎很费力似的。单位领导考虑到他不能 很好地胜任工作，只能让他休病假了。

请您根据王先生的状况写出一个名称（即此名称能形容王先生的问题）：_____

以下是可能导致王先生患上这问题的原因。请在原因程度表上画出您认为适当的数字（即在适当的数字上圈上一个圆圈，请参照例题）。请回答所有的问题而不要遗漏任何一个，问卷的填写对于本研究至关重要，即使您对任何一个项目不是十分肯定，也请画出一个您认为最适当的数字。填表指导：这份问卷由26个原因组成，每项均有0--4个数字，分别代表：

0=毫无关系，1=有一点关系，2=比较有关系，3=有关系，4=有很大关系

		原因程度表				
题号	王先生可能患上这问题的原因	毫无关系	有一点关系	比较有关系	有关系	有很大关系
例题	如您认为此原因与王先生出现的问题有很大关系，应在4号上划圈	0	1	2	3	(4)
1	王先生的问题根源是和先天遗传有关系	0	1	2	3	4
2	他是受过高等教育或者是知识丰富的人	0	1	2	3	4
3	现实生活与他的理想相差太远	0	1	2	3	4
4	这是跟更年期有关系	0	1	2	3	4
5	他失去了生活中最亲密的人	0	1	2	3	4
6	他是不幸运的或者他是命中注定会出现那些问题	0	1	2	3	4
7	他的事业受到了挫折	0	1	2	3	4
8	他的脑部或神经系统出现了问题	0	1	2	3	4
9	他的生活贫困并且生活得不顺心	0	1	2	3	4
10	他不太聪明也没有什麼本事	0	1	2	3	4
11	他成长的经历和常人不同（例如他被养大的方式）	0	1	2	3	4
12	他是受到了电视，报章杂志，小说或广播媒介的影响	0	1	2	3	4
13	他曾经与一些患有同样问题的朋友相处过	0	1	2	3	4
14	夫妻感情出现危机	0	1	2	3	4
15	他工作或学习的环境状况不好	0	1	2	3	4
16	他的工作压力太大	0	1	2	3	4
17	他身体的健康状况不佳而且抵抗能力不强	0	1	2	3	4
18	他受到鬼神的滋扰	0	1	2	3	4
19	他的家庭生活不和睦	0	1	2	3	4
20	他和同学，朋友或同事相处不融洽，人际关系出现危机	0	1	2	3	4
21	他的性格软弱（他不是一个坚强有毅力的人）	0	1	2	3	4
22	他的居住环境很差	0	1	2	3	4
23	是由于细菌或病毒的传染导致他出现那些问题	0	1	2	3	4
24	他的教育程度较低	0	1	2	3	4
25	他的生活习惯和常人不同（例如他的起居饮食和嗜好）	0	1	2	3	4
26	他缺少精神支柱	0	1	2	3	4

您如果认为还有其它原因能导致人出现类似问题，请您写在下面（如果您还需要地方请在背面继续写）：

第二部分

请您按项序回答下面的项目。如果我们给您留下的空格不够请您在背面继续写，并注明题号。（注：如需填写人的数量时，请您写清大约的数据）

1，在最近12个月之内，您在工作中遇到了多少人出现过类似王先生的问题？___人

（如填"0"，请跳到第12题）

2。类似王先生的病例，您亲自治疗过多少人？___人（如填"0"，请跳到第5题）

3，请您详细的介绍您给这些人治疗的办法及全部步骤，并写下治疗办法的名称。

_____

_____

_____

4，请您介绍一下在您给这些人治疗的过程中，您所用的治疗原理及理论。

_____

_____

_____

5，在最近12个月之内，在您所遇到过类似王先生问题的人中，您曾经建议过多少人找其他专家看病？

___人（如填"0"，请跳到第7题）

6，请写下您把他们转给了哪类专家，并说明为什麼选择了这类专家？

_____

_____

_____

7，在您所遇到过类似王先生问题的人中，您认为有多少人不需要治疗？___人（如填"0"，请跳到第9题）

8，他们为什麼不需要治疗？

_____

_____

_____

9，在您所遇到的类似王先生问题的人中，有多少人需要治疗但没得到治疗？___人（如填"0"，请跳到第12题）

10，他们没得到治疗的原因是什麼？

_____

_____

_____

11，您认为他们需要什麼样的治疗？

_____

_____

_____

12，依据上面的小故事，您认为王先生需要治疗吗？（请在下面画√）

需要_

不需要

（注：如回答"不需要"，请直接答第13题；如回答"需要"请跳到第14题）

13，请您解释一下王先生为什麼不需要治疗：

_____

_____

_____

14。您认为您是亲自给王先生治疗好，或者建议他找其他的专家？（请在下面画√）

建议找其他专家 ___

亲自治疗 ___

（注：如回答"建议找其他专家"请直接答第15题；如回答"亲自治疗"请跳到第16题）

15。如果您要建议王先生找其他专家治疗，您要给他建议哪类专家并说明为什麼选用这类专家？

_____
_____
_____

16。设想如果是您给王先生治疗，请您详细的介绍您将用的治疗办法及其名称，并详细的写清全部的治疗步骤。这种治疗的机制和理论是什麼？

_____
_____
_____

Appendix D

Professional subjects questionnaire (English version)

This questionnaire has two parts. You will first read story and then be asked to answer two sets of questions about the story. The information collected in this questionnaire will be used for a research project that is being conducted with the assistance and encouragement of Beijing University as part of a doctoral dissertation. The information obtained is confidential (we do not record your name, address, etc.) so please complete all of the questions according to what you really believe without consulting other people. Your participation is completely voluntary; you may stop completing the questionnaire at any time.

PLEASE FILL OUT THE FOLLOWING INFORMATION ABOUT YOURSELF (All information is anonymous, please do not write your name anywhere on the form)

Age ____ years ____

Years of completed schooling ____ years

When did you graduate from professional training (if you have two or more professional degrees please list date for most recent graduation)? : ____ year____ month

Years of work experience since graduation ____ year

Number of people in your household ____ persons

Average household monthly income ____ yuan

PLEASE PUT A CHECKMARK (√) BESIDE THE APPROPRIATE ITEM:

Type of profession: Western doctor ____ TCM medical doctor ____ Nurse: ____

Pharmacist ____ Acupuncturist____ Massage therapist ____ Psychiatrist ____

Psychologist ____ other (please specify): _____

Gender: Male ____ Female ____

Marital status: Single ____ Married ____ Separated ____ Divorced ____ Other ____

Place of birth (type) Urban ____ Rural ____

Place of birth (region) Northern China ____ Southern China ____

Section One

Below there is a short story, please read it carefully and then read the instructions and answer the questions that follow the story.

Mr. Wang has been experiencing some difficulties for the past three months. He reports that during this period he has been feeling sad for no apparent reason. He tells you that he has been feeling as though his life has no meaning and he feels hopeless about the future. He says that he has lost interest in doing almost everything that he previously enjoyed doing including his hobbies. He has been feeling irritable and sometimes argues with others over small matters. He has become increasingly withdrawn and says he has no desire to visit with friends or family. He reports that he has had difficulty going to sleep at night and that often he wakes in the middle of the night and has difficulty going back to sleep. He says that sometimes he awakens at about four o'clock in the morning and cannot go back to sleep. He tells you that, although he has not been trying to loose weight, his appetite has been poor and that he has lost about 20 pounds in the last three months. He reports that he has been feeling weak all over and has no energy, and that even the slightest exertion leaves him feeling so exhausted so that he frequently has to lay down and rest during the day. He reports that he has had headaches, stomach and back pain but that after many medical tests his doctor says there is nothing physically wrong with him. As a result of his difficulties he has not been able to work and his employer has told him to take sick leave until he gets better.

Given only the information in the story, what would you call the problem that Mr. Wang is experiencing? (What is the name of Mr. Wang's problem) _____

Below are 26 possible causes for Mr. Wang's problems. Circle one number beside each cause to indicate how important you believe each cause is (please see example below). Answer all of the questions without omitting any. The meanings of the ratings are as follows:

0 = Not at all important, 1 = Not very important, 2 = May be important,

3 = Likely important, 4 = Definitely important

#	Possible causes of Mr. Wang's problem:	Importance of possible causes				
		Not at all Important	Not very Important	May be Important	Likely Important	Definitely Important
Ex:	If you believe a cause is definitely important you would circle the number "4"	0	1	2	3	(4)
1	The problem is caused by his genetic disposition	0	1	2	3	4
2	He is too highly educated or affluent	0	1	2	3	4
3	His actual life status is too far below his expectations	0	1	2	3	4
4	His problem is due to menopause	0	1	2	3	4
5	He has lost someone very close to him	0	1	2	3	4
6	Mr. Wang is unlucky or predestined to have the problem	0	1	2	3	4
7	He has encountered many defeats in life	0	1	2	3	4
8	There is something wrong with Mr. Wang's brain or nervous system	0	1	2	3	4
9	He is too poor and unsatisfied with life	0	1	2	3	4
10	He lacks the intelligence or ability to manage things	0	1	2	3	4
11	His past experience (e.g., upbringing) is different from that of other people	0	1	2	3	4
12	He has been influenced by media (e.g., books, magazines, newspapers, television)	0	1	2	3	4
13	Mr. Wang has had interaction with friends having the same problem	0	1	2	3	4
14	He is experiencing marital problems	0	1	2	3	4
15	The environment in which he works/studies is not good	0	1	2	3	4
16	He has been suffering from a very heavy workload	0	1	2	3	4
17	His state of health and resistance of the body to germs is not good	0	1	2	3	4
18	Mr. Wang is disturbed by supernatural beings	0	1	2	3	4
19	His family life is not harmonious	0	1	2	3	4
20	He is not getting along well with her/his friends and/or colleagues (interpersonal crisis)	0	1	2	3	4
21	Mr. Wang has a soft personality (i.e., he is not a tough person, lacks willpower)	0	1	2	3	4
22	The environment in which Mr. Wang lives is not good	0	1	2	3	4
23	He is infected by bacteria or germs	0	1	2	3	4
24	He lacks formal education	0	1	2	3	4
25	His lifestyle is different from that of other people (e.g., eating habits, sleeping habits, any peculiar habits)	0	1	2	3	4
26	He lacks spiritual beliefs	0	1	2	3	4

Please write down any other possible causes that you may think of which we have not included in our list but that you believe to be important:

_____

_____

Section Two

Please read all of the questions before beginning to respond. If there is insufficient space to answer any of the following questions, please continue on the back of the page and mark your response with the associated question number.

1. In your professional practice during the past 12 months how many people have you seen with problems similar to Mr. Wang's?

Number of persons ____ (If none, please go directly to question 12)

2. Of the persons you saw with this problem, how many did you personally treat for the problem? ____ persons

3. What specific steps did you take to treat them?

_____
_____
_____
_____
_____

4. How does this type of treatment work?

_____
_____
_____
_____
_____
_____

5. Of the persons you saw with the problem, how many did you refer to other professionals to treat the problem?

____ persons (if none go to question 7)

6. To what type of professional did you refer them, and why?

_____
_____
_____

7. Of the persons you saw with this type of problem, how many didn't need any treatment what so ever for the problem? ____ persons (if none go to question 9)

8. Why didn't they need treatment?

_____
_____
_____

9. Of the persons you saw with this problem who needed treatment, how many didn't receive any treatment what so ever for the problem? ____ persons (if none go to question 11)

10. Why didn't these people receive the needed treatment?

11. What kind of treatment did they need?

12. Given only the information in the story, do you think Mr. Wang needs treatment?

No ____ (answer question 13)

Yes ____ (answer question 14)

13. Please explain why doesn't he need treatment:

14. Would you refer Mr. Wang to another professional or treat him yourself? (PLEASE CHECK ONE)

Refer ____ (answer question 15)

Treat ____ (answer question 16)

15. If you would refer him to another professional, to what type of professional would you refer him and why?

16. If you would treat his problem yourself, what steps would you take to help him and how would these measures work?