Narrated Experiences of Depression and Suicidality among Chinese Inpatients

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ABSTRACT

Suicide in China accounts for one-sixth of deaths by suicide worldwide and has drawn recent international attention (Yu et al., 2021). Studies have identified depression to be a major risk factor in suicidal behavior and estimate that up to 70% of Chinese people who die by suicide are depressed (Phillips et al., 2002; Lee, 2011; Wu, 2011). However, few studies have investigated experiences and meanings of suicidal behavior among people with depression in China.

Moreover, understandings of depression are changing rapidly in China (Lee, Kleinman, and Kleinman, 2007), and experiences of depression are culturally and contextually specific (Foucault, 1980; Lee, 1999). How do modern-day Chinese people with depression understand and experience their illness, what does it mean to them, and how does this relate to suicidal behavior?

This thesis seeks to understand experiences of depression and suicidal behavior (suicidal ideation and attempt) among psychiatric inpatients in Nanjing, China. I conducted and analyzed 142 qualitative interviews with adult inpatients diagnosed with a depressive disorder at Nanjing Brain Hospital. Interview transcripts were coded using an integrated approach that allowed for both inductive emergence and deductive organization of codes (Bradley, Curry, and Devers, 2007), and a high degree of inter-rater agreement was established among three coders. Based on participants' interview responses, I engaged theoretical frameworks regarding the social course and moral experience of illness and the role of culture in experiences of depression (Ware and Kleinman, 1992; Yang et al., 2014; Ryder and Chentsova-Dutton, 2012).

The data chapters (Chapters 3 to 6) are organized around participants' sociopsychosomatic experiences, moral experiences, somatic symptoms, and suicidality in the

context of depression. Chapter 3 elucidates how participants' understanding and experience of depression interacted with their interpersonal relationships and societal conditions. Chapter 4 identifies that "what mattered most" to participants was maintaining their roles within their families and discusses how depression threatened participants' "moral status" within their social contexts (Yang et al., 2014). Chapter 5 explores why participants tended to emphasize somatic symptoms and how this somatic emphasis interacted with stigma and medical help-seeking. Chapter 6 demonstrates how participants' motivations for suicidal behavior responded to experiences of suffering and impairment related to depression symptoms, their perceived inability to lead a moral life, structural factors that made mental healthcare difficult to afford and access (particularly for rural residents), and societal stigma and misinformation regarding disability, chronic illness, and mental illness.

This thesis furthers understanding of the complex interrelationships between social, moral, psychological, and somatic experiences of depression among Chinese inpatients, how these experiences are informed by cultural values and structural barriers to care, and how these experiences influence suicidal behavior. While the study offers one window into a specific set of experiences, it also presents implications for targets for depression treatment, anti-stigma intervention, and suicidal behavior prevention; highlights how structural issues with mental health service delivery interact with moral values in China; and informs future research on the intersection of depression, disability, and suicidal behavior.

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CHAPTER 1: INTRODUCTION

Suicide in China accounts for about one-sixth of deaths by suicide worldwide (Yu et al., 2021). Since the high rate of suicide in China in the 1990s drew international attention, there has been much debate about whether suicide in China is primarily a social or a medical problem (Zhao et al., 1994; World Health Organization, 2007). While Chinese psychiatrists and the Chinese government have increasingly promoted the idea that suicide is caused by depression, other psychiatrists and social scientists have emphasized the moral dimension of suicide in China (Zhang et al., 2002; Lee, 1999, Phillips et al., 1999). Historically, suicide in China has held rich cultural meaning as a "moral act" that responds to moral and social injustice (Wu, 2009). Some have argued that the medicalization of suicide could strip it of moral meaning and detach it from social causes that warrant wider attention (Kleinman and Kleinman, 1996; Lee, 1999).

Ethnographic studies on suicide in modern-day China have shown how suicide still has the power to "express a grievance" within local communities (Wu, 2011). However, these studies have also mentioned that Chinese people do not consider suicide caused by mental illness to have any meaning or moral significance (Wu, 2009; Wu, 2011). In addition, studies that have examined the meaning of suicide in modern-day China have mostly relied on the perspectives of the deceased person's family and community and focused on aspects of domestic conflict, rather than experiences related to mental illness, that may have motivated the suicide (Meng, 2002; Wu, 2011). Even as numerous epidemiological studies have now identified depression to be a major risk factor in suicidal behavior, and that up to 70% of Chinese people who die by suicide are likely depressed (Phillips et al., 2002; Lee, 2011; Wu, 2011), very few studies have investigated experiences and meanings of suicidal behavior among people with depression in China. As such, it is unclear what meaning suicide has for Chinese people with depression, how

depression “causes” suicidal behavior, and indeed what it would mean for depression to “cause” suicidality.

Moreover, depression itself is a relatively new and rapidly changing concept in China. Prior to the late 1980s, few people were diagnosed with depression in China; rather, 80-90% of psychiatric outpatients in the 1950s-70s were diagnosed with neurasthenia, which includes a constellation of over 70 (mostly somatic) symptoms (Kleinman, 1982). However, as China sought to modernize and gain international legitimacy, including in its psychiatric practices, it began to sideline neurasthenia as a diagnosis and adopt the more internationally-recognized depression instead (Lee, 1999).

While depression has become established among Chinese medical professionals and continues to gain acceptance in the lay population (Lee, Kleinman, and Kleinman, 2007), experiences of depression are culturally and contextually specific (Foucault, 1980; Lee, 1999). Studies of neurasthenia and depression in the 1980s-90s have shown how Chinese people’s experiences of these illnesses were intertwined with their interpersonal relationships and larger societal conditions, like the Cultural Revolution and its aftermath (Ware and Kleinman, 1992; Kleinman and Kleinman, 1994).

As Chinese society has transformed drastically since then, Chinese people’s experiences of depression have likely changed as well. How do Chinese people with depression now understand and experience their illness, and what meaning does it have for them? Moreover, how does this experience and meaning relate to suicidal behavior?

To shed light on these questions, this thesis seeks to understand experiences of depression and suicidal behavior among psychiatric inpatients in Nanjing, China, through analysis of in-

depth interviews. In this introductory chapter, I provide background on suicide and depression in China in order to contextualize elements of empirical data presented in later chapters.

Defining suicidal behavior

While definitions of suicidal behavior vary, this thesis will examine the following under the umbrella term "suicidal behavior": thoughts about wanting to die by suicide (suicidal ideation), plans to die by suicide (suicide plan), and attempts to die by suicide (suicide attempt). It does not consider acts of self-harm or behaviors that may be self-destructive but do not involve a desire to die by suicide (Silverman et al., 2007). It should be noted that some studies reviewed in the literature included broader definitions of suicidal behavior, including, for example, wanting to die or feeling that life is meaningless without necessarily wanting to die by suicide.

Suicidal behavior trends in China

Estimates of the prevalence of suicidal behavior can vary widely and be subject to limitations in reporting. Data on national suicide rates in China were not available until 1987 due to the government's general reluctance to publicize possible social issues (Phillips et al., 1999). Though the Ministry of Health (MOH) began providing suicide data to the World Health Organization (WHO) in 1989, suicide may still be a politically sensitive topic (Lee, 1999). In addition, the lack of a complete nationwide vital registration system means that official figures are based on unrepresentative samples that cover less than 10% of the population and include disproportionately high numbers of urban residents (Phillips et al., 2002a). The same data can also produce different results depending on what adjustments are made to the raw numbers—estimated rates in 1990 using the same data ranged from 13.9 to 30.3 per 100,000 (He et al., 1999; Murray et al., 1996). On an individual level, stigma against suicide may discourage self- and family reports of suicidal behavior and distort cause-of-death figures. Inconsistent

definitions of suicidal ideation, like “ever seriously thought about committing suicide” or “ever thought of ending your life,” may also lead to varying estimates. Altogether, available numbers likely underestimate the prevalence of suicidal behavior, providing, as Cao et al. noted, a floor rather than a ceiling (2015).

Despite the caveats above about the trustworthiness of the data, it seems clear that in the past three decades, the rate and pattern of suicide in China have undergone drastic changes (Naghavi, 2019). In the 1990s, China’s suicide rate was among the highest in the world and exhibited a unique gender distribution. Female suicide rates exceeded male rates by an average of 26%, while global reports usually showed higher male rates of suicide and higher female rates of suicide attempt (Zhao et al., 1994; Ji, Kleinman, and Becker, 2001; World Health Organization, 2007; Desjarlais et al., 1995). Rates by age revealed a bimodal distribution, with a peak among adults over age 65 and a smaller peak among adolescents and young adults between the ages of 15 and 34 (Phillips et al., 2002a). Rural rates were consistently three to five times higher than urban rates among men and women across all age groups, with 93% of the nation’s suicides occurring in rural areas (Yang et al., 2004; Xiao et al., 2003). Many have stated that the high rate of suicide among rural women in particular largely accounted for China’s high national suicide rate and uniquely high female suicide rate (Law and Liu, 2008).

Nearly three decades later, China’s suicide rate is now considered one of the lowest in the world. The most recent national figure placed China’s suicide rate at 9.7 per 100,000 in 2016 (World Health Organization, 2019). The Global Burden of Disease study estimated that China’s suicide rate decreased by 64% between 1990 and 2016 (Naghavi, 2019). Zhang et al. (2014) also noted a significant decline in China’s suicide rate between 2002 and 2011 based on data from the National Population Census and MOH.

The distribution of suicide in China has also changed since the 1990s. The gender discrepancy narrowed, approaching near equivalence (World Health Organization, 2019). Some studies reported that male rates even began to surpass female rates in the mid-2000s (Zhang et al., 2014; Wang et al., 2014). While rural suicide rates remain higher than urban rates, the difference is also decreasing. From 2002 to 2011, rural suicide rates were on average two times higher than urban rates, compared to three to five times higher in the 1990s. The peak among young adults seems also to be subsiding, such that the age distribution instead demonstrates a clear increased risk of suicide with age (Zhang et al., 2014).

Many studies have attributed these changes to improving economic and living conditions, greater rural-to-urban migration, and increasing opportunities for rural young women (Wang et al., 2014; Yip et al., 2005). However, Wang et al. (2014) noted that while the overall suicide rate declined, rates in young males did not decrease, and rates in urban and rural older adults (both men and women) actually increased, posing a significant concern for China's aging population.

While less studied, suicidal ideation and suicide attempts show similar patterns. In their meta-analysis of eight studies published before 2014, Cao et al. (2015) estimated the pooled prevalence of lifetime suicidal ideation and suicide attempts in China to be 3.9% and 0.8%, representing 50 million and 10 million people, respectively. Suicidal ideation was 1.7 times more prevalent among females than males, and suicide attempts were 2.2 times more prevalent among females than males, but only the difference in suicide attempts was statistically significant. No significant differences in suicidal ideation or attempts were found between rural and urban residents, despite the recorded higher rate of suicide among rural residents. Cao et al. attributed this discrepancy in part to the greater accessibility of lethal suicide methods, namely toxic pesticides, in rural areas, leading to a higher case fatality rate of rural suicide attempts. In that

case, the government's recent concentrated efforts to reduce the availability of toxic pesticides in rural areas may also account for the nation's declining suicide rate (Caine, 2013).

Overall, while suicidal behavior may be difficult to measure accurately, the high rate of suicide in China in the 1990s drew international attention and sparked debate about the characteristics and reasons for Chinese people's suicide. Although China's suicide rate has now decreased to one of the lowest per capita in the world, China's large population means that suicides in China still account for about one-sixth of global suicides (Yu et al., 2021). Moreover, the continued high rate of suicide among elderly adults represents a problem for China's aging population.

Changing meanings of suicidal behavior in China

Suicide in China has also attracted attention because its cultural meaning may differ from the meaning of suicide in Western countries. In Chinese history and literature, suicide has been done for moral reasons—to demonstrate loyalty to rulers, protest injustice, and protect women's chastity, for example (Wu, 2009). As times have changed, ideas of suicide in China have changed as well. In particular, suicide has increasingly become tied to depression in Chinese medical and public discourse, posing implications for the changing meaning of suicide in China (Lee, 1999).

Historical meaning of suicide in China

Wu (2009) delineated how, historically, suicide in China has held great social significance and political potency—suicide served to upset the immediate or larger social order but could be appropriated to support certain ideologies. As moral alignments changed with the times, so too did the acceptable justifications for suicide, though the potential for suicide to signify moral resistance largely remained (Wu, 2009).

As Wu (2009) observed, in Chinese intellectual history attitudes toward suicide seem to be based more on the perceived reasons for suicide than the act of suicide itself. After two men committed suicide out of loyalty to their overthrown king, Confucius (551-479 BCE) judged their actions to be virtuous because they died to uphold their values, but stated that he would not have chosen the same path. When asked about the virtue of another man who chose not to attempt suicide under similar circumstances, Confucius praised the man's accomplishments in later life and suggested that there were better methods than suicide of contributing to humanity. Based on these accounts, Confucius' attitude seems to have been that suicide was an imperfect choice that could be justified under the right circumstances (Wu, 2009).

Later Confucian thinkers varied slightly in their view of suicide. Mencius (372-289 BCE) encouraged valuing virtue over life while Xunzi (310-235 BCE) criticized one man's suicide for defying the political order. Virtue, wisdom, prudence, and political harmony all represent Confucian ideals, and a suicide could uphold some values while undermining others. While some intellectuals may have regarded suicide for the sake of virtue as imperfect or improper, they did not consider it immoral because of the valiant intent behind the act (Wu, 2009).

Perhaps the most well-known suicide in Chinese history is that of Qu Yuan (340-278 BCE), a poet and high official who drowned himself after a messenger from a warring state deceived the king into banishing him. In an attempt to rescue him and save his body from desecration, villagers rowed to the middle of the river and threw in food to distract the fish, a tradition that has transformed through the years into the Dragon Boat Festival (Wu, 2009).

In late imperial times (1368-1912), intellectuals customarily committed suicide upon a change of power to demonstrate loyalty to the overthrown leaders and resist the new dynasty. Those who did not were often considered cowardly or traitorous (Wu, 2009).

During this time, women also died by suicide to protect their chastity and by extension their virtue—a Neo-Confucian saying claims that chastity is worth more than life (Wu, 2009). While the women were not expected to commit suicide, their deaths were often venerated with monuments or aestheticized in literature (Sommer, 2000; Carlitz, 2001). In theory, the Qing government (1644-1912) attempted to curb rates of suicide by rendering people who completed the act ineligible for honors. However, the frequent exceptions it granted for suicide in the name of chastity contradicted this intention (Theiss, 2001). Although stories of female suicide in this era held great cultural influence, Wang (2003) pointed out that many women committed suicide for reasons other than chastity and were posthumously assigned a narrative of Confucian virtue by the state.

The social significance of suicide could also be seen several centuries later, in the response to the 1919 suicide of Zhao Wuzhen, who slit her throat in the bridal chair rather than marry the man her family had arranged for her. Mao Zedong published over nine articles on the subject, holding traditional society and its patriarchal customs to task for Zhao's death. Mao believed that Zhao may not have truly wanted to die but had no other choice of obtaining free will and happiness (Witke, 1967). Yet Mao also critiqued the shortsightedness of her suicide—the best way of achieving free will and happiness, Mao wrote, was through social revolution rather than individual suicide (Wu, 2009).

Perhaps ironically, anecdotes of widespread suicide among people persecuted in the Maoist era characterized the trauma of the Cultural Revolution (Da, 1993). While protest may not have been the individuals' intentions, the government's suppression of such stories speaks to suicide's potential for censure and disruption (Lee, 1999).

While accounts in Chinese history may have differed on the acceptability of suicide, it seems clear that suicide has been interpreted to have great political, social, and cultural potency. In addition, it has been understood to arise from and respond to social and moral issues (Wu, 2009). However, as Chinese economic reform ushered in Western views of suicide in the 1990s, some have argued that the meaning of suicide has changed with medicalization (Lee, 1999).

Medicalization of suicide: Depression as part of the meaning of suicide

In fact, depression has come to comprise a greater part of the meaning of suicide. Given China's comparatively low rates of depression and alcoholism in prior decades, many suicide researchers initially cautioned against applying a biomedical view to suicide in China (Lee, 1999, Phillips et al., 1999). Yet Chinese psychiatrists have increasingly promoted the view of suicide as a medical issue resulting from depression (Lee, 1999). Lee (1999) noted how two keynote lectures given at the third national conference on crisis intervention and suicide in 1996 demonstrated Chinese medical professionals' growing support for a connection between suicide and depression. The lecturer, a prominent Chinese suicide researcher, claimed that the key to preventing suicide in China was early treatment for depression, primarily with antidepressant medication (Zhai, 1996; Lee, 1999).

Lee (1999) and Phillips (1999) argued that, while the medicalization of suicide helped draw resources and attention to suicide prevention efforts, it may also have distorted the social meaning of suicide in China. When suicide was primarily viewed as resulting from family conflict and domestic affairs, it may not have made sense or been appropriate for those outside the family, including the state, to intervene. After all, a popular saying instructs that "domestic shame should not be made public" (Lee, 1999). As suicide became known as more of a medical issue, however, it became more acceptable as a topic of public discussion and involvement. Data

on suicide was made publicly available, and stories on people who died by suicide appeared in newspapers and women's magazines. Professional groups like the Committee on Risk Prevention of the Chinese Association of Mental Health (1994) formed, numerous national conferences were held, and telephone hotlines began offering help to people in distress (Phillips, 1999). In effect, suicide became treatable both in theory and in practice, as the government dedicated resources to crisis intervention, public awareness, and medical therapy (Lee, 1999).

Though the locus of suicide prevention shifted outside the family, the meaning of suicide became concentrated in the individual. By implicating individual pathology rather than social ills, the biomedical view of suicide detached suffering from its political, economic, and cultural context (Kleinman and Kleinman, 1996). Lee (1999) argued that medicalization obscured the moral significance of suicidal acts, ignoring for example the gendered social forces behind China's high rate of young rural female suicide at the time. Under medicalization, suicide prevention hinged not on social change but on the robustness and penetration of medical systems. The moral urgency of suicide became subsumed by medical authority, which homogenized the experience of suicide at the same time that it stripped it of its collective meaning (Kleinman and Kleinman, 1996; Lee, 1999).

The espoused connection between suicide and depression is likely to have influenced lay conceptions as well. The deaths of numerous prominent celebrities, including Qiao Renliang, Shang Yubo, Jia Hongsheng, Chen Baolian, and Leslie Cheung, in China, Hong Kong, and Korea in the 2000s and 2010s have been attributed to depression-induced suicide and received massive attention in popular publications and on social media (Yip et al., 2006; Fu and Yip, 2007; Leung, 2019). While this coverage raised awareness of depression among the general

population, it may also have reinforced the perceived relationship between depression and suicide, influencing cultural interpretations of both (Leung, 2019).

Overall, despite pushback from some academics, suicide has become treated largely as a medical issue by the Chinese government and media, which have increasingly attributed suicide to depression. While this medicalization can increase transparency around suicide data and draw more resources to suicide prevention via improved access to mental healthcare, it could also hinder suicide prevention by obscuring possible social drivers of suicide, which some have argued contribute more to suicidal behavior than depression does.

Contemporary understandings of suicide in China

From the late 1990s to the present, suicide research in China has grappled with this question of what drives suicide in China in the modern-day. Different disciplines have taken complementary approaches—epidemiologists have sought to identify risk factors for suicidal behavior while anthropologists and sociologists have examined the meaning that suicide holds for rural Chinese communities, where suicide rates are highest.

Risk factors and models for suicidal behavior in China

Epidemiologists in China have identified risk factors of suicidal behavior and tested theoretical models of suicidality. The role of mental illness, and particularly depression, in suicidal behavior has been an object of focus.

Studies in the 1990s found a uniquely low prevalence of mental illness among Chinese people who died by suicide. In a comprehensive review of Chinese suicide research between 1992 and 1998, Zhang et al. found that 72.5% of suicide cases had been attributed to interpersonal reasons like family conflict and marriage issues, while only 3.9% had been connected to psychiatric diseases (2002). While in the 1990s over 90% of suicide subjects in the

U.S., U.K., and Europe had a diagnosed mental illness, and 60% had depression, less than 30% of suicide subjects in China were identified as having had any mental illness (Law and Liu, 2008).

This discrepancy begged the question of whether depression was actually less prevalent among suicide subjects in China or if the difference mainly resulted from methodological issues. Depression in China was likely underdiagnosed at this time, as one study found that only 5% of people with depression received treatment, and another showed that only 30% of suicide attempters had sought psychological help (Murray and Lopez, 1996; Li et al., 2002). This low rate of help-seeking may have been due to inaccessible mental health services, limited knowledge about mental illness, and a prevailing idea that suicidal behavior resulted from social stressors rather than medical issues. Even if people had sought medical help, linguistic and cultural barriers may have limited the ability of Western diagnostic instruments to detect depression in Chinese subjects, who may have presented psychological distress in different ways (Phillips et al., 2002b; Phillips et al., 2007).

Using a more culturally appropriate instrument, Phillips et al. conducted a nationally-representative psychological autopsy study and found that 40% of suicide subjects had likely had a depressive illness, as determined through interviews with family members and close associates of the deceased (2002b). Though this study found a greater proportion of depressive illness than previously reported, Phillips et al. maintained that mental illness did not play a large role in the deaths they examined. Rather, the suicides represented impulsive acts by people suffering acute stress brought on by recent negative life events and interpersonal conflicts. While these individuals may have experienced intense psychological distress at the time of death, the transience of their symptoms may not have qualified them for a full depressive diagnosis.

Phillips et al. therefore cautioned against focusing preventive efforts on *either* mental illness *or* social stressors and instead advocated for a multifactorial approach that recognizes a dose-dependent contribution of multiple risk factors, including high depression symptom score, previous suicide attempt, exposure to family and friends with suicidal behavior, acute and chronic stress, low quality of life, and recent intense interpersonal conflict (2002b; 1999).

More recent studies in China have identified depression as a major risk factor for suicidal behavior and noted the role of sociocultural conditions and stressful life events as significant predictors as well. A 2012 meta-analysis of 44 studies reported that mood disorders and stressful life events increased the risk of suicidal ideation and attempts across all Chinese demographics. People in rural areas, with mood disorders, with lower education, and/or with previous negative life events were at higher risk of completed suicide (Li et al., 2012). Similar predictors emerged in studies that explored the particular risk factors of China's rural population. Liu et al. (2018) found that the prevalence of mental disorders was 32.3% for people who had attempted suicide compared to 4.9% for paired controls in rural China. The most common mental disorder was major depressive disorder among women and alcohol use disorder among men. In addition, suicide attempters at higher ages were more likely to have a mental disorder (Liu et al., 2018). Niu et al. (2020) found that loneliness, hopelessness, and depressive symptoms elevated the risk of completed suicide among older adults in rural China. Studies among rural youth also found mental disorders, high hopelessness, and recent severe life events to be strong predictors of suicide (Zhang et al., 2010; Li et al., 2008).

Models for suicidal behavior have mostly grappled with these interactions between mental illness and social stressors as explanatory variables. The general academic perspective seems to have progressed past the binary of a mental illness model or a social stress model.

While the mental illness model explains nearly all suicide as products of mental disorders, a social stress model portrays suicide as primarily a social problem and may include mental illness as a less common, isolated factor (Phillips et al., 1999). Instead, contemporary models for suicide in China tend to consider how mental disorders and social stressors dynamically interact to determine suicidal behavior risk. Phillips et al. (1999) proposed a framework for understanding suicide in China that includes five interacting factors: cultural beliefs in the afterlife and acceptability of suicide, social problems that challenge one's morals or social place, predisposing psychological problems, availability of suicide means, and availability of suicide prevention services.

Other studies have explored the applicability of pre-existing theories to suicide in Chinese contexts. Zhang et al. (2011) tested the strain theory of suicide, which extends from Merton (1957) and Agnew's (1992) strain theory of social deviance and suggests that suicide follows experiences of psychological strain. This strain consists of at least two competing pressures, such as differential cultural values, aspiration vs reality, one's status vs that of others, and crisis vs coping skills. Zhang et al. found that these last three forms of strain were significantly associated with suicide even after accounting for mental illness in a Chinese sample, which may challenge the West's predominant psychiatric model of suicide (2011). Yang et al. (2019) tested Klonsky and May's (2015) three-step theory of suicide, which posits that suicidal ideation begins with a combination of psychological pain and hopelessness, progresses toward action when pain exceeds social connectedness, and results in attempt or completion when one has the psychological or practical capacity for suicide. In a study with Chinese undergraduates, Yang et al. found moderate support for the role of psychological pain and hopelessness in driving suicidal ideation, strong support for the role of connectedness as a

protective factor, and strong support for practical variables like access to lethal means and related knowledge in predicting suicide attempt. Based on these findings, they emphasized the particular importance of social support and community preventive measures in a collectivist Chinese context (2019).

Moral meanings of contemporary suicide in China

While epidemiologists have used quantitative data to try to predict suicide risk, social scientists have used ethnography to explore the meaning of suicide within local Chinese communities where suicides have occurred. In particular, they have connected suicide to moral conflicts within the family and showed how rural young women are particularly vulnerable to suicide because of their low position in the family hierarchy and oppressed place in Chinese society (Meng, 2002; Wu, 2011).

Decades after Mao wrote about the revolutionary implications of Zhao Wuzhen's suicide, sociologist Meng Liu (2002) also interpreted one rural young woman's suicide as an act of rebellion and revenge. In a village in southeast China, the woman, Fang, committed suicide after an argument with her husband and mother-in-law at the culmination of a turbulent marriage and in-law relationship in which she was never fully accepted by her husband's family. Meng gathered the perspectives of the in-law family, who viewed the suicide as a foolish act; the natal family, who blamed the in-laws for Fang's death; and the villagers, who stoked rumors that Fang had been taken by ghosts. Meng however noted the strength of the suicide in forcing a role reversal within the family. Fang's in-laws had to arrange her funeral, rather than the other way around, and bow to her memory. In death Fang achieved the acceptance she had been denied in life. Her natal family demanded expensive and formal funeral rites in her honor, and she received a prominent burial in the in-law family's cemetery (Meng, 2002).

Meng claimed that, in addition to being a symbolic act of rebellion, Fang's suicide also represented a form of revenge. Her suicide destroyed the reputation of the husband's family, which was seen as having mistreated a daughter-in-law to death. While villagers gossiped about each side's culpability, they also attempted to alleviate their own sense of responsibility by assigning a mystical explanation to Fang's death. In disrupting the family's oppressive hierarchy, Fang's suicide demonstrated the power that rural Chinese women held in death and lacked in life (Meng, 2002; Pearson, 2005).

Because Meng's interpretation occurred post-hoc, it is impossible to know whether these motivations actually informed Fang's death. Lester (2011) quipped that Meng's assessment represented "the meaning of suicide for the suicidologist" more than the suicide's personal or cultural meaning, which remained unclear without further evidence. Nevertheless, Meng's analysis extends if not a lay perspective then at least an intellectual cultural tradition of noting suicide's symbolic significance in the face of oppression.

Wu (2011) also studied suicides in rural China and related them to moral injustice within the family. Through anthropological fieldwork, Wu examined over 200 cases of suicide in a northern county and concluded that most of the people who died by suicide did so to resist a family member's violation of their expectation of moral treatment. Wu situated this conclusion within the context of Chinese morals, where family and family harmony are paramount. Maintaining family harmony often involves negotiating family politics, which includes love and affection as well as moral responsibility. Suicide then becomes "a strategy in playing these family games of power"—a move to gain dignity, protest a grievance, and resist "domestic injustice" (Wu, 2011). Wu described cases of wives who were unjustly blamed by husbands during conflicts with in-laws and parents who felt disrespected by children. While the suicides

may have seemed to be in reaction to trivial arguments, what was at stake were much deeper moral and emotional commitments, which may be thrown into new and more complex conflicts as Chinese society modernizes and values evolve (Wu, 2011).

Moreover, Wu (2011) claimed that while some of the people who died by suicide may have become depressed from their family problems, the depression did not seem to be directly responsible for the suicide. Rather, family conflict was the root cause of both the depression and the suicide, which may not have been causally linked to each other.

Thus, both Meng (2002) and Wu (2011) concluded that rural suicides in China were due in large part to family conflicts and the moral relationships involved. Symptoms of depression, if evident to others, were related effects of the family conflicts but usually not direct causes of suicide (Wu, 2011). While Wu (2011) stated that depression did not seem to be a direct cause of the suicides, he did not elaborate on what would make depression be considered a direct cause.

Suicidal behavior among people with mental illness: Devoid of meaning?

While Meng (2002) and Wu (2011) provided deep analyses of how rural Chinese people interpret suicide and its associated meaning, it remains unclear how suicidal behavior is viewed when associated with depression. The people Wu (2011) studied who had depressive symptoms likely did not have a depression diagnosis and were not viewed by others as having a mental illness.

Wu (2011) discussed one case of suicide by someone with a cognitive disability, who was referred to by villagers as a "fool" (a highly pejorative term). While he apparently died by suicide after a conflict with his cousin, who slapped him in front of several people, his suicide was not taken seriously by others in the community. Because he had a mental disorder, he was not considered to be a "full person" capable of moral acts. As suicide was understood to be a

moral act, the villagers did not think his suicide even counted as suicide and interpreted his death to be valueless and meaningless (Wu, 2011). As such, it seems that when a mental illness is understood to be the "cause" of someone's suicide, the act of suicide is viewed to be irrational, amoral, and therefore devoid of significance (Wu, 2009).

As awareness of depression grows in China and suicide increasingly becomes attributed to depression, it remains to be seen how understandings of depression alter the meaning of suicide in China.

Depression in Chinese sociocultural context

The discourse on suicide in China is thus inseparable from discussion of depression's changing role in Chinese psychiatry and its particular cultural manifestations. While biomedicine promotes the premise that psychiatric disease categories are stable, isolable, and for the most part universal, many have challenged this assumption and described psychiatric classifications as products of particular social, political, historical, and economic forces on local and global scales (Foucault, 1980; Lee, 1999). Moreover, experiences and understandings of illness are not fixed but rather change dynamically with these social forces over time. Depression in China reveals the influence of globalization and modernization in the past few decades, while also retaining distinctive characteristics rooted in culture and history.

Psychiatry in Chinese history

Cheung-ming et al. (2015) traced psychiatric concepts in traditional Chinese medicine back to at least 1100 BCE, when medical literature began including words for conditions similar to mania (*kuang*) and psychosis or epilepsy (*dian*). Traditional Chinese medicine, which dates back to at least 2780 BCE, emphasizes harmony within one's internal forces as well as between internal and natural forces in a sort of mind-body-nature equilibrium (Cheung-ming et al., 2015).

These internal forces are conceptualized as circulating "vital energy" (*qi*) and blood, and disturbance of these forces forms the explanatory model of illness. Emotions are thought to stem from the concentration of *qi* in certain organs like the lungs (sadness), liver (anger), kidneys (fear), heart (joy), and spleen (worry), which also correspond with the elements of metal, wood, water, fire, and earth, respectively. Emotional disturbances are also thought to result from some disruption of the vital forces, like blockage of gas or blood, an unnatural amount of fire or heat, and depletion or stagnation of *qi*. In this holistic view of health, not much separation exists between mental and physical illnesses, as the mind and body are intimately linked. Cheung-ming et al. (2015) suggested that these long-standing conceptions of health continue to influence Chinese people's use of embodied language to express emotional experiences.

As Cheung-ming et al. (2015) documented, in later centuries, Chinese physicians began to more systematically categorize illnesses based on observation and experience. The book "Etiology and Symptomatology of Diseases" in 700 AD included over 40 psychiatric symptoms grouped into causal categories. In the 1600s, Wang Kentang created a classification system for psychotic states, including conditions similar to mania and psychosis, and neurotic states, including conditions like restlessness, agitation, panic, and phobia (Liu, 1981; Cheung-ming et al., 2015).

As contact with Western countries increased in the late 19th century, Western psychiatric models gained traction as well. Medical missionaries set up psychiatric hospitals and training centers that mostly employed harsh containment and correctional measures in accordance with Western medical thinking at the time. By 1949 over 2000 psychiatric beds were established across 9 major cities (Xia and Zhang, 1986; Parry-Jones, 1986).

In subsequent years, as China's political landscape underwent dramatic transformations, psychiatric knowledge followed suit. When the Maoist era rejected the pollution of Western ideas from 1949 to 1960, Western psychiatry was also dismissed as "bourgeois pseudoscience." China instead adopted the Soviet view that mental illness resulted from purely biological factors and was akin to neurological disease (Xia and Zhang, 1986). As China began to distance itself from the Soviet Union and champion national self-sufficiency during the Great Leap Forward of the 1960s, recovery from illness also became a matter of self-reliance. Mental hospitals closed down, and the few that remained were limited to custodial care of the insane (Cheung-ming et al., 2015; Lee, 1999). Instead, neighborhood communes were expected to collectively fight any mental illness among its members by renewing their revolutionary spirit and serving their country. In fact, signs of mental distress defied the ideal of revolutionary optimism and represented sociopolitical critiques of the Chinese Communist Party (Ho, 1974).

After the Cultural Revolution ended in 1976, China began opening up to international influences once again, and this was reflected in the 1979 creation of the Chinese Classification of Mental Disorders (CCMD), a psychiatric diagnostic manual published by Chinese psychiatrists. The CCMD was modeled off the International Classification of Diseases (ICD) and Diagnostic and Statistical Manual of Mental Disorders (DSM) but contained some tailored differences, including addition of about 40 culturally relevant diagnoses and exclusion of some irrelevant Western diagnoses (Lee, 2001).

The CCMD has since been revised many times, in 1981, 1984, 1989, 1995, and 2001, reflecting not only the pace of change in global psychiatry but also the degree of transformation in China's psychiatric practices (Lee, 2001). One of the psychiatric classifications that has

transformed the most is neurasthenia, a diagnosis that has often been considered the precursor to depression in China.

From neurasthenia to depression

Perhaps partly due to the political sensitivity of mental illness at the time, the diagnosis of neurasthenia gained widespread popularity in China during the 1950s-80s. Coined by U.S. neurologist George Beard in 1869, the term neurasthenia described a form of nervous exhaustion and was characterized by over 70 somatic, emotional, and cognitive symptoms, including fatigue, weakness, difficulties with concentration and memory, and headache. While the once-popular diagnosis fell out of use in the U.S. in the early 20th century, it reached China through Russia or Japan (Lee, Kleinman, and Kleinman, 2007) at around the same time and became adopted as *shenjing shuairuo*, which roughly translates to "nervous weakness." Neurasthenia's non-hierarchical constellation of symptoms seemed to resonate with nondualistic mind-body concepts in traditional Chinese medicine. Its core characterization of somatic weakness further aligned with ideas of *qi* and its depletion or stagnation (Lee, 1999; Lee, Kleinman, and Kleinman, 2007). Neurasthenia thereby offered a culturally relevant illness concept and non-stigmatizing alternative to the folk characterization of *jingshenbing*, which tends to describe severe forms of psychosis (Kleinman, 1988; Hall et al., 2018). In the context of the Cultural Revolution, neurasthenia resisted political interpretation and provided a sanctioned avenue of expressing distress or avoiding party demands (Kleinman, 1982). As such, while few people were diagnosed with mental disorders like depression in the 1950s-70s, 80-90% of psychiatric outpatients were diagnosed with neurasthenia (Liu, 1982; Kleinman, 1982).

After China entered its reform period in the late 1970s, neurasthenia persisted in popularity, remaining the most common non-psychotic diagnosis in the 1980s (Cheung, 1991;

Zhang et al., 2007). However, in the face of Western disregard for neurasthenia, many Chinese psychiatrists began to question the nosological legitimacy of neurasthenia (Lee, Kleinman, and Kleinman, 2007). The Diagnostic and Statistical Manual of Mental Disorders 3rd edition (DSM-III), which rapidly expanded into a global standard of psychiatric practice after its publication in 1980, did not include neurasthenia. Further, using diagnostic criteria from the DSM-III, Kleinman (1982) reported that 87 of the 100 neurasthenic Chinese patients he interviewed could have been classified as having some form of depression and responded favorably to antidepressant medication. In its quest for socialist modernization, China perceived itself as technologically backward and globally alienated and sought international legitimacy, including in its psychiatric practices (Lee, 1999). Neurasthenia came to represent a crude and outdated viewpoint, despite its clinical utility among Chinese patients. As various Chinese studies echoed Kleinman's 1982 finding, reporting that 30 to 70% of China's neurasthenic patients likely suffered from depression, the prevalence of neurasthenia fell and that of depression rose (Zhang, 1989). The CCMD-2, published in 1989, advised that clinicians exclude all other psychiatric disorders before making a diagnosis of neurasthenia (Young, 1989). While neurasthenia as a diagnosis may still persist in rural clinics, it has largely disappeared from Chinese academic psychiatry and is rarely seen in urban hospitals. Instead, depression became established among Chinese medical professionals and continues to gain acceptance in the lay population, particularly among young, urban, educated Chinese (Lee, Kleinman, and Kleinman, 2007).

Sociopsychosomatic characteristics of neurasthenia and depression

While most people who would have been diagnosed with neurasthenia several decades ago in China are ostensibly being diagnosed with depression now, neurasthenia and depression in China retain some culturally and socially specific characteristics.

For one, Kleinman, Kleinman, and Good (1985) noted how people's experiences of neurasthenia were closely tied to their social experiences, particularly their experiences of the Cultural Revolution and its aftermath. People attributed their distress to traumatic things that happened to them as a result of China's political upheaval, as well as to enduring feelings of disempowerment, interpersonal strife, disillusionment, and disorientation related to their social conditions (Ware and Kleinman, 1992). These feelings were reflected in their primary symptoms—exhaustion, pain, headaches, insomnia, and dizziness—which functioned as "embodied metaphors" for their distress (Ware and Kleinman, 1992; Kleinman, Kleinman, and Good, 1985). Thus, people's psychosomatic experiences of neurasthenia were closely related to their experiences of social suffering.

Moreover, people with neurasthenia and depression in China tended to emphasize somatic experiences. In his early studies, Kleinman noted that, unlike Western patients who tended to privilege psychological symptoms, Chinese patients with neurotic disorders emphasized somatic symptoms like those of neurasthenia, including headaches, insomnia, dizziness, and bodily pains. This observation led Kleinman to describe a phenomenon of "Chinese somatization," wherein bodily idioms of distress characterize social and personal problems (1977, 1982, 1986). Kleinman also connected somatization to political contexts like the Cultural Revolution and posited that somatic symptoms communicated distress in a socially and politically acceptable manner (1986, 1997).

Since then, many studies have confirmed the predominance of physical complaints among mainland Chinese and Chinese diasporic people with depression in Taiwan, Hong Kong, and the United States (Chang, 1985; Parker et al., 2001; Ryder et al., 2008). Studies have also found that this type of somatic presentation of distress predominates in much of the world, such

that “Chinese somatization” is not exclusively Chinese and “Western psychologization” may be more of a global anomaly (Kirmayer, 2001; Parker et al., 2002; Ryder et al., 2008). While somatization may not be uniquely Chinese, the primacy of somatic symptoms in Chinese depression may reveal certain cultural understandings and social contexts that influence Chinese people’s experiences of this illness.

Since Chinese people’s experiences of neurasthenia were shown to be intimately linked to social conditions of the time, and somatization has been hypothesized to be due to social norms as well, the present-day social, psychological, and somatic experiences of depression in China warrant further study. Lee, Kleinman, and Kleinman (2007) conducted an ethnographic study on experiences of depression in an outpatient mental health service in China. They found that people interviewed tended to express “embodied emotional experiences,” where emotional distress was felt in the body, and particularly emphasized sleeplessness as the origin of their problems. Participants also described symptoms like irritability and bad temper that have generally not been treated as clinically meaningful but that suggest distress from disharmony in interpersonal relationships. Study participants assumed their sadness was evident and inevitable given their somatic symptoms and social situations. From these findings, Lee, Kleinman, and Kleinman indicated that dominant psychiatric knowledge does not adequately encompass Chinese experiences of depression—particularly the bodily and social aspects involved—and called for further studies integrating understanding of depression symptoms with analysis of sociocultural contexs (2007).

Research questions

Based on the reviewed literature, it is evident that there is little understanding of the meaning and experience of suicide among people with depression in China. In order to

understand this, there is also a need to understand the meaning and experience of depression in present-day China.

Qualitative research is especially suited to examining the experience and meaning of particular phenomena in context (Denzin and Lincoln, 2005). In addition, Chinese inpatients with depression are likely to have significant and meaningful experience with depression and suicidal behavior. Therefore, this study will use qualitative research methods to investigate two overarching research questions among Chinese depressed inpatients: What were participants' social, moral, psychological, and somatic experiences of depression? How were participants' experiences of depression related to suicidal behavior?

Participants' interview responses led me to engage relevant theoretical frameworks regarding social and moral experiences of illness that will be discussed further in individual data chapters. Based on a combination of what participants emphasized in interviews and what emerged from the reviewed literature, the data chapters are organized around participants' sociopsychosomatic experiences of depression, moral experiences of depression, somatic symptoms in experiences of depression, and suicidality in the context of depression.

In the next chapter, I discuss the methods I used for this research.

CHAPTER 2: METHODOLOGY

In this chapter, I explain my interview methodology and analytic strategy. I describe the study setting and population, as well as my sampling choices. I also discuss efforts to enhance the trustworthiness of the data.

Study site

Choice of psychiatric clinical setting

The study did not use a community sample because of ethical issues involved with selectively interviewing mentally ill individuals within some communities. Without also interviewing non-depressed controls, a community study may expose participants' identities and subject them to stigma and social harm (Lee, Kleinman, and Kleinman, 2007). A primary care setting also was not used to avoid disproportionately selecting for patients with somatic presentations of depression.

Nanjing Brain Hospital

The study was conducted at Nanjing Brain Hospital in Nanjing, China. Nanjing is the capital of Jiangsu Province in eastern China and the eighth largest city in the nation, with a population of over 8.5 million (China National Bureau of Statistics, 2019). Nanjing holds jurisdiction over six urban districts, five suburban districts, and five rural counties. As of 2015, over 1.7 million Nanjing residents were rural-to-urban migrants, or people who had moved from rural to urban areas without changing their permanent residency, or *hukou* (Jiangsu Provincial Bureau of Statistics, 2016).

Nanjing Brain Hospital, or the Affiliated Brain Hospital of Nanjing Medical University, was founded in 1947 as China's first national neuropsychiatric hospital, which treats neurological and psychiatric illnesses. Its inpatient psychiatric departments include closed and

open units, and treatment methods include medication, psychotherapy, electroconvulsive therapy, and transcranial magnetic stimulation.

As one of the only psychiatric specialist hospitals in the region, it provides care to more than 18,000 inpatients and 800,000 outpatients from across Jiangsu Province and neighboring provinces each year, though the majority of patients are from Nanjing (Nanjing Brain Hospital). This geographic reach contributed to the sample's diversity in terms of residence and birthplace.

Access

Access to Nanjing Brain Hospital was facilitated by the Dean of Nanjing Medical University's School of Public Health, Dr. Yankai Xia, who introduced me to a psychiatrist, Dr. Xiangrong Zhang, with whom he had a prior working relationship. Dr. Zhang is the senior physician of one of the psychiatric units at the hospital. He introduced me to his team, as well as the senior physicians of seven other psychiatric units, which allowed me to access eight psychiatric units at the hospital. The patients in these units were primarily being treated for depressive disorders, anxiety disorders, bipolar disorder, and schizophrenia.

Familiarization with the site

Before beginning the study, I familiarized myself with the study site by shadowing Nanjing Brain Hospital psychiatrists during inpatient rounds and outpatient visits over the course of a month. Through shadowing and talking to doctors, I got to know the hospital's operations and learn more about their patient population and approach to treating depression. This knowledge informed my choice to sample an inpatient population over an outpatient one and helped me tailor my interview questions later on.

Choice of inpatient setting

After observing the hospital's operations, I chose an inpatient setting over an outpatient setting for logistical and ethical reasons. The high volume and rapid turnover of patients in the outpatient clinic made it difficult to conduct extended, private interviews. Moreover, most outpatients and their accompanying family members took time out of work or other obligations to come to the clinic, so a study that would prolong their visit would likely be met with reluctance or create additional burden on the participants.

Ethical approval

Ethical approval was obtained through Yale University's Institutional Review Board and the Institutional Ethical Committee of Nanjing Brain Hospital. Ethical considerations for the study will be discussed throughout the chapter.

Recruitment of participants

Eligibility and exclusion criteria

Adult inpatients (at least 18 years old) with a primary diagnosis of a depressive disorder were eligible to be interviewed. Exclusion criteria included current symptoms of psychosis, mania, or cognitive impairment. Hospital psychiatrists determined which patients met the inclusion and exclusion criteria.

Sampling

Beginning in November 2020, I approached eligible inpatients in two psychiatric units to participate in interviews. After I had approached all eligible patients of those units, I moved on to two new units, while cycling back to previous units to interview any newly admitted eligible patients. Each unit had about 40 inpatients with various psychiatric diagnoses at a time, and inpatient stays tended to last at least two weeks, with some lasting over a month. The response rate was 81%.

I interviewed 142 participants before reaching theoretical saturation, or when no new concepts were being introduced by further interviews (Patton, 2014). Because I wanted to understand relevant experiences of participants of various genders, age groups, and urban/rural residence, I interviewed more participants than might be typical of a qualitative study to get a diversity of perspectives (Bradley, Devers, and Curry, 2007). Participants' demographic characteristics are presented in the table below.

Table 1. Participant demographics

Gender	
Male	38 (27%)
Female	104 (73%)
Age	
Median	54 years
Minimum	18 years
Maximum	83 years
Days in hospital at time of interview	
Median	10 days
Min	1 day
Max	67 days
Highest level of education	
No education	18 (13%)
Elementary school	19 (13%)
Middle school	30 (21%)
Middle vocational school	11 (8%)
High vocational school	14 (10%)
High school	20 (14%)
College and above	30 (21%)
Birthplace	
Urban	64 (45%)
Rural	78 (55%)
Residence	
Urban	91 (64%)
Rural	51 (36%)
Marital Status	
Never Married	30 (21%)
Married	93 (65%)
Divorced/Widowed	19 (13%)

Informed consent

All participants provided verbal consent to be interviewed and audio recorded. Participants were provided with a printed consent form, which was also read aloud to them, since many patients could not read. Since the study took place in a clinical setting, the consent form emphasized that their decision to participate in the study or not would have no effect on any treatment they would receive nor on their relationship with Nanjing Brain Hospital. Participants were told they could change their mind about participating at any time, and they could also refuse to answer any question without providing a reason.

Participants were encouraged to ask questions during and after the consent form was read. To ensure that participants understood the terms of consent, I asked them five questions about the consent form after the form was read, including a question on whether their participation in the study would affect their treatment or relationship with the hospital. If participants answered incorrectly, I explained the terms and asked the questions again.

Semi-structured interviews

Topic guide

Recruited participants took part in a semi-structured interview that included questions modeled off the DSM-5's Cultural Formulation Interview, which elicits understanding of the patient's subjective experience of illness, their ideas of their illness, and relevant cultural and contextual factors (American Psychiatric Association, 2013). The interview topic guide (included in the appendix) had a set of open-ended questions and topics to cover while allowing for flexibility based on the flow of the conversation.

Participants were first asked in an open-ended manner to describe their problem and then were asked about their symptoms, what they think caused their illness, how they talk about their

illness with others, coping mechanisms and social support, help-seeking experience, and desires for treatment. If it did not come up already in the interview, participants were then asked if they had ever thought about wanting to die or not wanting to live anymore. If they answered affirmatively, they were then asked if they had ever thought about ending their life, and the conversation continued from there.

The topic guide was developed after observation of inpatient and outpatient operations at the site and conversations with hospital clinicians. Two native Mandarin speakers, including a psychiatrist at the hospital, checked the questionnaire for linguistic and cultural appropriateness. Three pilot interviews were conducted to improve the validity of the questionnaire, resulting in some questions being modified to enhance clarity.

Conducting interviews

Interviews were conducted one-on-one in Mandarin and digitally recorded, and ranged between 30 and 70 minutes. Since the study occurred in an inpatient setting, interviews took place in the patient's room or in a private room in the unit.

Given the sensitive and potentially upsetting nature of the subject matter, I took care to minimize distress that may be incurred during the interview. Talking about depression and suicidal behavior can trigger negative emotions and memory of past traumas (Jorm, Kelly, and Morgan, 2007). Participants were reminded before the interview that they could stop the interview at any time and did not have to answer any question they did not want to. Throughout the interview, I consistently noted participants' expressions and body language. If participants appeared distressed, I gave them time to cry, vent, and regroup as needed (Draucker, Martsolf, and Poole, 2009). I was careful not to probe too much if a participant seemed like they really did

not want to discuss something. Since participants were inpatients in a monitored environment with clinical staff, there was little risk of them physically harming themselves or others.

While talking about difficult experiences can trigger negative emotions, it can also offer a sense of release, connection, empowerment, and self-awareness (Newman and Kaloupek, 2004). Some have objected to the idea that participants need to be shielded from feeling negative feelings, which might not necessarily be harmful or adverse (Becker-Blease and Freyd, 2006). As such, I tried to navigate these emotions with sensitivity but not avoidance during the interview.

Many participants valued the opportunity to talk about their experiences and were eager to share their thoughts. Some participants said they had shared things during the interview that they had never had the chance to tell anyone else. Some said the experience of talking and being listened to during the interview had made them feel better. People can fear burdening friends or family by talking about negative feelings, and the stigma related to mental illness in China can discourage people from talking about their illness with people they know. Additionally, in most cases, doctors were not able to talk to patients for extended periods of time, and counselors were difficult to access. As such, many participants expressed that the interview was their first time talking in-depth about their experiences with depression.

Given the novelty of discussing their illness in-depth, many participants were making meaning and sense of their illness in real time. This was evidenced by contradictions and revision of prior statements within the same interview, indicating the multifaceted and complicated nature of their experiences with the subject matter. Participants were asked to clarify or elaborate on certain ambiguities, but the nuances of their ambivalence were also taken into account.

Rapport and reflexivity

In the course of this research, I reflected on how I would be perceived by participants, what my preconceptions of the subject matter were, and how these factors might affect what was discussed during the interviews (Berger, 2013). In addition, I attempted to build rapport with participants during the interview such that they might feel comfortable speaking freely.

As a Chinese American, I was an outsider in some ways and an insider in others. The fact that I was from the United States and had no personal connection to Nanjing may have made participants feel more comfortable talking about personal matters, knowing that I could not be part of their network. They also may have been more willing to explain things about Chinese culture or society that otherwise may have been implied or euphemized. Being from the United States, I tried not to impose my own ideas about depression and suicide onto the conversation and tended to use terms and pursue topics that participants brought up themselves.

At the same time, being ethnically Chinese and speaking Mandarin may have created a sense of commonality and shared understanding between us. Having been brought up with Chinese culture, I was familiar with certain relational dynamics, idioms, manners, and values. This may have helped put participants at ease and encouraged the flow of conversation. I also tried to note if anything participants implied seemed evident to me but may not be to someone unfamiliar with Chinese culture and asked participants to expand on some points explicitly, if appropriate.

While there is often a power imbalance between researcher and participant, my age and student status may have helped to offset some of this imbalance. Given that a greater degree of respect is afforded to people who are older in China, my age (22 years) meant that I was in a lower position than most participants and close to a peer to younger participants. In addition, I

introduced myself as a research student who was there to learn from them, such that participants were positioned as the higher authority on their own experiences. Although participants sometimes asked me what I knew or thought about depression and suicide, I mostly found ways to turn these questions back to participants' own knowledge and thoughts on these matters so as not to bias the discussion.

Anonymity and confidentiality

Interview recordings were encrypted and password protected. No participants' names or contact information were collected. Interview transcripts contain no identifying information. Participants were assured that information shared during the interview would be kept confidential, which was important for establishing trust and minimizing risk given the potential stigma of depression and suicide.

Data analysis

Analysis was an ongoing process that began in the data collection phase and continued throughout the writing phase (Braun and Clarke, 2020). The analytic strategy involved familiarizing myself with the data, documenting ideas in analytic memos, creating and refining a codebook, generating themes from coded material, and reviewing themes for consistency with the data (Braun and Clarke, 2006; Bradley, Curry, and Devers, 2007). There are many different ways to conduct qualitative analysis and differing views on how it should be conducted. The approach I took attempted to balance these views by establishing a degree of coding reliability while also recognizing the necessarily interpretive role of the researcher in constructing themes from the data (Bradley, Curry, and Devers, 2007).

Transcription

Interviews were transcribed by the researcher verbatim in Chinese, with notations for nonverbal communications like pauses, laughter, crying, sighs, etc., and supplemented with notes taken at the interview. The audio and transcript for each interview were reviewed multiple times to achieve understanding of and immersion in the data.

While the relative benefit of translating at different stages of analysis has often been debated in cross-language qualitative research (Squires, 2009; Santos et al., 2015; Abfalter et al., 2020), I chose to analyze the transcripts in their original language to retain the nuance of localized expressions and the unique character of the Chinese language. For example, Lee, Kleinman, and Kleinman (2007) and Pritzker (2007) have commented on the embodied language Chinese people have used to describe experiences of depression, as well as emotions more generally. This characteristic of language lends itself to rich metaphorical meaning and denotes a particular experience of illness that may become lost in translation. Moreover, since language has often been recognized to influence thinking, transcripts in this study were kept in Chinese to reduce early interpretive bias by researchers that may limit analysis and curtail opportunities for ongoing dialogue among collaborators (van Nes et al., 2010; Temple and Young, 2004).

Memos

While collecting data and familiarizing myself with the data, I documented initial observations of patterns within the data in analytic memos. These patterns could occur within one interview or across many interviews. These memos helped me consider participants' words within the context of their narratives, as well as within the larger context of the dataset. Later on in the analysis process, I returned to these memos when checking whether my themes were consistent with the data and the context of participants' narratives.

Coding

To analyze the transcripts, an initial codebook was developed using an integrated approach that allowed for both inductive emergence and deductive organization of codes (Bradley, Curry, and Devers, 2007; Saldaña, 2012). The codebook employed three levels of conceptual codes and subcodes and included a definition and example quote for each code (Creswell, 2017). This initial codebook was then refined in discussion with two other coders. All three coders were bilingual in English and Mandarin and coded the same three transcripts independently.

After independently coding the three transcripts, the coders met to discuss their coding choices, as well as any ambiguities or disagreements in the application of codes. Most disagreements were resolved through discussion. Inter-rater reliability (IRR) was assessed for each pair of coders by dividing the number of agreements between coders by the total number of coded sections for each transcript. Since the total number of coded sections differed for each coder, each pair of coders produced two IRR values. An IRR of 80% agreement on 95% of the codes was established to reduce interpretive bias and increase consistency of coding (Miles and Huberman, 1994).

The rest of the interviews were then coded in NVivo using the refined codebook. The coding structure is included in the appendix.

Themes

Patterns and relationships in the data that were relevant to the research questions were captured as themes, which were revised in relation to the codes and their corresponding data extracts (Braun and Clarke, 2006; Bradley, Devers, and Curry, 2007). After coding, I considered how different codes related to each other or combined to create “shared meanings” and contribute to overarching patterns (Braun and Clarke, 2012). In constructing themes, I thought

about how different themes created an overall narrative picture of the data, whether a theme meaningfully answered the research questions, how much of the data a theme captured, and how much data there was to support a theme (Bryne, 2021). I constantly reviewed the themes in relation to the codes and dataset to check that the themes were consistent with the codes and data and that the themes provided an appropriate interpretation of the data in relation to the research questions (Patton, 2014; Braun and Clarke, 2006). Codes and themes were revised as part of this process.

Translation of data excerpts

In reporting the study findings, I selected data excerpts that illustrated a theme or communicated an aspect of the data. Translation contains some degree of interpretation in and of itself (Squires, 2009; Santos et al., 2015; Abfalter et al., 2020). In translating data excerpts, I tended to keep the translation literal, while explaining terms that may have connotations that are not evident in a literal translation. For some key expressions, such as phrases that recurred in interviews or terms participants used to describe symptoms, I discussed the meaning and translation of these expressions with the two bilingual and bicultural coders, as well as with two other bilingual and bicultural individuals. Translations of data excerpts were checked for accuracy and preservation of meaning by one of the bilingual and bicultural individuals.

Trustworthiness of data

Efforts were taken to minimize researcher bias and enhance the trustworthiness of the data. By creating a codebook and establishing inter-rater reliability, I increased the chance that a different coder would apply the same codes to the same data (Miles and Huberman, 1994). To minimize bias in translation, translations of data were discussed and checked by multiple bilingual and bicultural individuals (Abfalter et al., 2020).

However, in interpretative analysis it is inevitable that some degree of researcher interpretation is involved, and indeed, researcher interpretation is considered an essential component of constructing themes from the data (Braun and Clarke, 2019). To increase rigor in this interpretive process, I critically reflected on my role as a researcher, my relationship with the data, and my preconceptions and biases related to the subject matter (Berger, 2013). Interpretations of data were sense-checked with my supervisor, two coders, and two other bilingual and bicultural individuals (Braun and Clarke, 2013). In reporting the study findings, I strove to be transparent about my research choices, to show how the themes were informed by the data through use of data excerpts, and to provide context of the study setting and population to inform assessment of the study findings' transferability to other situations (Guba and Lincoln, 1994; Patton, 2014).

CHAPTER 3: SOCIOPSYCHOSOMATIC EXPERIENCES OF DEPRESSION

Participants' social contexts featured prominently in their narrated experiences of depression. Participants described dynamic, complex relationships between the symptoms they experienced and their interpersonal relationships and social circumstances.

Their characterizations reflected what Ware and Kleinman (1992), Kleinman et al. (1995), and Ware (1999) termed the "social course of illness," in which social and cultural influences—as manifested through everyday social interactions—affect what and how symptoms are felt over time and shape how illness is experienced in day-to-day life. The idea of illness having a social course, in addition to a biological course, conveys that the experience of illness is a shared social experience that is dynamically and longitudinally constructed among the individual and the people in their lives (Ware, 1999).

Ware and Kleinman (1992) used the case of neurasthenia in China in the 1980s to illustrate how social problems and interpersonal experiences related to bodily distress. Their study subjects ascribed the cause of their neurasthenia to the trauma of the Cultural Revolution and the disillusionment that followed it. Their core symptoms reflected those experiences—exhaustion, pain, and dizziness functioned as "embodied metaphors" for disempowerment, "painful social relations" in the family and at work, and imbalance and disorientation in response to the rapidly changing political climate of the time and its effect on day-to-day lives. This linking of social experience to psychological and somatic experiences led Ware and Kleinman to conceptualize illness as "sociopsychosomatic." While the example of neurasthenia concerns large-scale political and cultural movements, "enduring cultural values and ongoing everyday processes" also mold how illness is experienced and develops over time (Ware, 1999).

This "sociopsychosomatic" formulation of illness was apparent in the illness beliefs and symptoms that participants described in interviews. Participants' explanatory models of illness, symptomatology, and ideas for recovery reflected their conceptions of intertwined relationships between mind, body, and society, such that societal and interpersonal disharmony translated into mental and bodily suffering.

Explanatory models of illness: social disharmony and individual inability to cope

Explanatory models of illness refer to patients' conceptions of what caused their illness (Gidron, 2013). In participants' explanatory models of illness, psychosocial factors caused and exacerbated somatic problems, which in turn contributed to emotional distress in a mutually reinforcing cycle. If left unbroken, this cycle eventually developed into what participants considered an illness, or something abnormal that required intervention. While participants usually believed interpersonal disharmony contributed to the onset of this cycle, many also blamed themselves for "thinking too much" and not coping well enough with social stressors.

Social causes

Participants often attributed their illness to social causes, including conflicts in marital, family, work, and neighborhood relationships; work and financial pressures (providing for the family); changes in living environments; and illness within the family. They drew connections between these social stressors and the onset or worsening of their bodily problems.

An urban Nanjing participant explained how, three months ago, she had become ill after being "disturbed" (*chao*, 吵) by her husband's snoring. At that time, she had been undergoing a difficult pregnancy and lost a large amount of blood, prompting her admission to a hospital. Her husband, whom she described as a heavy drinker, had been out drinking and arrived at the hospital late at night.

> *My husband came later at 12:35 am, extremely drunk, and slept on the other side of the hospital room. At the time I wasn't angry with him, but I definitely wasn't happy. His snoring was too noisy (*chao, *吵). The sound of his snoring while he is drunk is very noisy, and it disturbed (*chao, *吵) me all night. It was also that day, on August 19, that I stopped sleeping.* [case 22-6-12-5, female, age 42]

The participant's narrative of her illness begins with this story about her husband's snoring. She described only being able to sleep one to two hours, if at all, each night since then, up until the night before our interview. She attributed her sleeplessness to being "sensitive to noise" (*pachao,*怕吵). Through the course of the participant's narrative, it becomes increasingly apparent that there is distress in her marriage—she expressed being dissatisfied with her husband's drinking and upset by him flirting with women online, which she said later contributed to further sleeplessness. She described how, when she "let go" or stopped caring about her husband's flirtation the night before our interview, she was finally able to get a good night's sleep.

The participant's husband's snoring while drunk served as a route through which the interpersonal distress of her marriage "got under her skin," or became translated into bodily suffering in the form of sleeplessness. In Chinese language, "*chao*" means "noisy," as well as "to quarrel" and "to disturb." Placed in the context of her narrative of illness, her complaint about being "sensitive to noise" implicitly contained an anxiety about relational disturbance and the negative emotions attached to it.

In the participant's explanatory model, the initial disturbance (husband's snoring) produced her sleeplessness, which caused further suffering in the form of chest pain, headaches, irritability, low mood, and a feeling like ants were crawling all over her skin. Over time, these symptoms mutually reinforced each other until they became difficult to untangle.

> *Because I was disturbed, I became sleepless; because I was sleepless, I became depressed; because I was depressed, I became even more sleepless. It's a vicious cycle,*

> *like whether the chicken came first or the egg, both are the cause and the effect.* [case 22-6-12-5, female, age 42]

Many participants shared in her conception of the "vicious cycle" of psychological, social, and somatic stressors that combined to produce depression as an illness. While participants attempted to tease out cause and effect in their explanatory models to make sense of their illness, their social, psychological, and somatic experiences were so intertwined and co-occurring that this seemed like a "chicken and egg" situation.

In addition to interpersonal causes, some participants also referenced broader societal conditions, like poverty and inequality, as factors in their illness. While these larger social forces transcended interpersonal relationships, they often exerted their influence through an interpersonal route—in other words, the distress of these social conditions was often experienced via the distress they produced in participants' interpersonal, day-to-day lives.

For example, one 72-year-old participant started our interview by complaining about corruption in the Chinese government and the unfair treatment of the working class. Throughout the interview, she criticized government officials for enjoying a private supply of organic vegetables while ordinary people could only access food poisoned by pesticides, which she said gave her the colon cancer she was recently diagnosed with. She attributed the corruption to a societal shift to valuing money over morality in China, which has undergone accelerated political, economic, and cultural change in her lifetime.

When asked what brought about her depression, she identified familial conflict as the source, which nonetheless was closely related to the societal problems she described.

> *My spirit being bad has to do with conflict…with my family…with my children. They only think that everything is good. Now with Chinese economic reform, their lives are good, they have jobs, so they think everything is good. They're young, they don't know what things were like before, maybe deep down they think as long as they are doing well, then things are good, without thinking about others.* [case 14-6-12-13, female, age 72]

This conflict with her children at once reflected her sense of despair towards larger Chinese society and also served as the most proximal cause of her distress, which was experienced as low mood and whole-body aches. In the course of the interview, she mentioned that she did not have anyone to look after her after her colon surgery two months ago, that she was unable to live with her children despite wanting to, and that her children were too busy with their jobs to mind her. This contradicted the Chinese moral value of filial piety, which holds that children should be devoted to their parents (Yan, 2011).

> *This is the most painful thing for me, not having kin. It's not only me, it's a problem faced by every family in China now. The children have all changed. I say, people are all eating so much genetically modified food, it's like people's genes have been modified too. Some wives have become other people's wives, husbands have become other people's husbands, everyone has become genetically modified. Children are leaving home, haven't they become genetically modified? The people are all gone, they aren't Chinese people anymore. Society has become so shameless.* [case 14-6-12-13, female, age 72]

Here, what could be understood as three separate threads in the participant's narrative converge—her concern about unhealthy modern-day food becomes a metaphor for her to understand how Chinese society and Chinese people, including her children, have fundamentally changed. In this way, societal distress is at once interpersonal distress and bodily distress. The larger issues she has with Chinese society act on her mind and body via her interpersonal relationships and the food she consumes, producing her "sociopsychosomatic" experience of illness.

Individual causes

Although participants often located the source of their distress in their social environments, they also identified an element of individual blame. They frequently attributed their depression to personal predispositions and behaviors, the most prominent of which was "thinking too much" (*xiangtaiduo*, 想太多). "Thinking too much" referred to ruminating on

emotions or events to the point of distress, and related idioms mentioned by participants included "taking things too hard" (*xiangbukai,* 想不**开**, literally translated as being unable to think openly), "putting things in the heart" (*fangzaixinli,* 放在心里), and "not letting go" (*fangbukai,* 放不**开**). These idioms contain both cognitive and emotional components, reflecting a sense of not being able to figure out, make peace with, or let go of something.

An urban male participant's description of depression reflected how the interplay of social relationships and individual characteristics was held responsible for the onset of depression.

> *I think, depression, how to understand it? It's just the brain thinking too much, thinking too much all day, something like that. People will only become depressed if there's unfairness in life, unfairness in the home, plus maybe disharmony between the husband and wife. Under the average person's circumstances, how would someone become depressed?* [case 10-16-12-17, male, age 37]

His account indicates a tension and ambivalence about understanding depression as a product of social problems versus a product of individual actions. While participants believed that social disharmony may be a crucial impetus to distress, they also believed the individual possessed some culpability in holding onto this distress, by choice or by personality, and incubating it into an illness.

In participants' understanding, "thinking too much" reflected a poor ability to adapt to social stressors and a disconnection from others. In this way, despite being an individual behavior, "thinking too much" nevertheless described a particular, aberrant relationship with one's social world. An urban male participant described how "pushing things in the heart" involved being closed off from others and how this disconnection created his illness.

> *I personally know that I have a heart sickness (xinbing, 心病). I don't wish to share with others, and sometimes I push things inside my own heart. My personality is too introverted (*neixiang, *内向,* literally: inward-facing*), and I don't wish to share with*

> *others, I push things in my heart, and it's become my own heart sickness.* [case 18-3-12-10, male, age 31]

In this way, depression was seen to represent and result from disharmony between an individual and their social surroundings. The participant believed he fell ill because he failed to engage with his social environment in a "healthy" way. As reflected in participants' explanatory models, both social disharmony and an individual's inability to restore harmony contributed to pathology.

Ultimately, in many participants' accounts, psychosocial distress was enacted in the body. In the next section I describe participants' embodied experiences of distress.

Symptomatology

Chief complaints

To understand participants' chief complaints, or the primary problems they were seeking help for, participants were asked what brought them to the hospital. If they said simply "depression," they were asked what symptoms in particular were bothering them. Participants were able to name multiple chief complaints. Chief complaints named by at least 5% of participants are listed by decreasing order of frequency in Table 2.

Table 2. Chief complaints

Chief complaint category	Number of participants	Specific complaints
Sleeplessness	78	
Head discomfort	62	Dizziness (晕/昏): 30, Headaches (痛): 23, Swollenness (胀): 5, Heaviness (重): 2, Stuffiness (闷): 1, General discomfort (难受): 1
Anxious feelings	59	Anxious (焦虑): 24, Impatient (急躁)/urgent (急): 13, Panicked (心慌): 12, Nervous (紧张): 5, Worried (操心/发愁): 3
Depressed feelings	48	Low mood (低落): 19, Depressed (忧郁/抑郁): 13, Unhappy: 10, Wanting to cry: 6
Lacking energy/vitality	37	No energy (没劲)/fatigued (疲劳): 28, No vitality/spirit (没精神): 9
Lacking appetite	31	
Irritable feelings (烦)	27	
Heart discomfort	20	Uncomfortable: 14, Swollen (胀): 2, Damp (潮): 2, Burning (烧): 1, Blocked (堵): 1
Stomach discomfort	17	Pain (痛): 9, Uncomfortable: 5, Swollenness (胀): 3
No motivation/ability to do things	16	
Whole-body pain/discomfort	14	
Thinking too much (想不开/想太多/胡思乱想)	12	
Restless/uneasy (坐立不安/静不下心来)	11	
Loss of interest/meaning	11	
Chest discomfort	11	Stuffiness (闷): 7, Pain (痛): 4
Suicidal thoughts/attempts	10	
Sweating	9	
Fast heartbeat	9	
Self-harm	9	
Nauseau	8	
Memory difficulties	8	

It should be noted that the symptoms listed are participants' chief complaints and not all the symptoms they experienced. In naming their chief complaints, they are likely prioritizing what they most wanted medical treatment for.

Nevertheless, it is interesting that some of the most commonly named symptoms (sleeplessness, dizziness, exhaustion, headaches) remain the same as the primary symptoms that were observed among neurasthenia patients in China in the 1980s (Kleinman, Kleinman, and Good, 1985), suggesting that there may be some core experience of neurasthenia/depression in China that has persisted despite the shift in diagnostic labels. At the same time, a greater proportion of participants named psychological symptoms related to anxious and depressed feelings compared to neurasthenia patients studied in the 1980s (9%), indicating that there may also be greater awareness and openness around discussing psychological symptoms now (Kleinman, Kleinman, and Good, 1985).

It is also worth noting that many participants named somatic symptoms like sleeplessness and dizziness as their chief complaints. This somatic emphasis will be explored further in Chapter 5, but in this chapter, I will take a deeper look at how participants described their experiences of distress, beyond the chief complaints they listed.

While choosing one or a few chief complaints compelled participants to simplify what might be complex and ambiguous experiences, participants discussed more nuanced pictures of their sociopsychosomatic symptoms when narrating their experiences of illness.

Embodied experiences of distress

Psychological and somatic symptoms not only mutually reinforced each other in participants' explanatory models, but also intertwined in participants' felt experiences of illness. The embodied nature of participants' experiences was embedded in language and extended

beyond language to felt sensations. Social distress and emotional states were located in the body metaphorically and literally, as described by one rural Nanjing participant who spoke of long-term strife with her husband.

> *I don't want to mind [my husband], so I just stuff it all in my heart (*menzaixinli, *闷在心里). I don't want to tell my daughter either, and I don't want to tell other people, I can only let myself slowly digest it in my stomach. It takes many days to digest, and sometimes when I remember it, it becomes stuck in my chest. This is how it's slowly turned into this illness. Whenever I bring him up, my chest gets blocked. When I see him talk, the anger starts in my heels, and I hate him so much. Why do I hate him? It's impossible for me to have gotten this kind of illness on my own. I used to not talk, I never let out a squeak at anything, I put everything in my heart (*fangzaixinli, *放在心里).* [case 14-9-12-13, female, age 62]

As the metaphorical nexus of emotions and consciousness, the Chinese word for "heart" (xin, 心) is better translated as the "heart-mind" (Yu, 2002). By "putting things in her heart," this participant was also "keeping things in mind," or putting emotional and ruminative weight on them. In addition to being stored in the heart, emotions were figuratively digested in the stomach, spread through the body from the heels up, and congested in the chest. Physically, they manifested as what this participant described as a burning feeling over her heart, burning sensations and hot air throughout her body, and digestive problems, which the participant said were shown by physical exams to include chronic gastritis. Chronic gastritis may be variously considered an effect, cause, or comorbid condition of the participant's depression, but in the context of her narrated experience, the indigestion of her emotions and indigestion in her stomach were felt as one and the same. The physical exam simply provided further evidence of what she felt to be true, which was the anger's physical presence in her body.

Though not everyone pinpointed their emotions to specific areas of the body, participants described similarly interwoven relationships between the metaphorical heart-mind and the

physical body. For example, one participant explained how her heart-mind could feel pain in other parts of the body, as well as possibly produce that pain.

> *When I feel unwell, I will feel in my heart that I hurt everywhere, I'm uncomfortable everywhere, I don't want to do this, I don't want to do that, I find it all bothersome.* [case 22-17-12-5, female, age 52]

Another participant described the heart-mind circumscribing the body, such that conditions of the heart-mind could debilitate the body.

> *My body can't go on anymore, my heart is oversensitive (*xinxi, *心细) and panicked (*xinhuang, *心慌).* [case 13-20-11-14, female, age 76]

Sometimes, experiences of the heart-mind were felt literally in or over the physical heart.

> *In moments when I am stressed, my heart will feel rather painful. For a time, I was even worried that there may be something majorly wrong with my breasts.* [case 17-18-12-10, female, age 35]

As such, participants' emotional states were frequently reflected in their bodily sensations. The embodied nature of emotions and emotional character of bodily experience often made it hard for participants to delineate the somatic from the psychological. These aspects of experience interacted dynamically with the social context as well.

Notably, participants often described feelings of suffocation and congestion, which mirrored feelings of being unable to release emotions and being blocked or closed off from others. "Putting things in the heart" and related idioms not only functioned as metaphorical expressions; they were also felt as physical pain, swollenness, and suffocation. A lack of flow between an individual and their social world was embodied as a lack of flow in the body, lending another layer of meaning to symptoms like "head swollenness" (*touzhang,* 头胀), "heart swollenness" (*xinzhang,* 心胀), and "chest tightness" (*xiongmen,* 胸闷), which participants frequently attested to and that previous studies documented as Chinese cultural idioms of distress (Lee, Kleinman, and Kleinman, 2007). Participants often described feeling as though something

was stuck or could not "come out" of their body, preventing essential things like food or air from entering.

> *This fieriness I feel is like a concentrated pain, like the pain of eating a hot pepper. My heart becomes hot, like the fire can't come out, and then I just don't want to do anything, I can't even eat.* [case 14-38-12-3, female, age 68]

> *I also feel as though my heart is going to explode, like I can't take a single step, like there's a breath of air that can't come out and I'm going to suffocate to death.* [case 17-18-12-10, female, age 35]

It is important to note that while participants often viewed psychological and somatic experiences as interconnected, overlapping, and at times indistinguishable, these symptoms were not always inseparable. For some participants, low mood persisted while chest pain dissipated, or poor sleep remained while negative thoughts cleared. While it can often be reductive and dualistic to distinguish between "somatic" and "psychological" symptoms, participants organically made such distinctions, which influenced their help-seeking behavior and understanding of their illness. This tension between experiencing emotions, physical sensations, and social distress as one phenomenon and simultaneously emphasizing one dimension or another will be explored further in Chapter 5.

Ideas for recovery: Interpersonal support, medical help, and self-regulation

Participants' ideas for what would help them recover from depression were related to their explanatory models and experiences of symptoms. Just as being "closed off" was thought to bring on illness, alleviation of symptoms required "opening up" by letting go of distressing thoughts and emotions.

Sometimes, this process of letting go involved finding a social outlet for discussing problems and feelings. In this way, participants' social relationships played dynamic roles in their recovery as well as their distress.

> *If I talk, and it makes me feel happy, then I'll talk a bit. If I need someone's help, then I'll talk a bit. This way it feels smoother to breathe, otherwise, I feel bad having it all buried in my heart. If I talk and my heart feels more comfortable, then I'll talk a bit.* [case 22-17-12-5, female, age 52]

> *Now [after inpatient psychiatric treatment] I feel like I should be able to open up/let go (*fangkai, *放开), be able to think openly (*xiangkai, *想开). In any case no one experiences smooth sailing all the time. If one encounters hardships, there are also family members to discuss with, right? It's just like this, helping each other arrive at solutions.* [case 17-18-12-10, female, age 35]

For these participants, engaging with their social relationships could help them achieve and maintain a sense of bodily and psychological openness, which relieved the symptoms of their illness.

However, this method of recovery was complicated by the social withdrawal that often accompanied participants' depression.

> *I don't want to go out, don't want to see people. Other people want to eat with me, friends with good intentions invite me out to eat, they remind me ahead of time that I have to go eat with them. Then I'm very tangled up, for many days I'm tangled up. I just think how am I going to go eat this meal. Because I'm afraid of noise/disturbances (chao, 吵). And I'm afraid of walking out this door.* [case 10-37-12-18, female, age 65]

As being disconnected from others was thought to contribute to depression, depression symptoms also caused further disconnection from others, presenting another vicious cycle.

"Opening up" could also result from conditions of the body. For some participants, alleviation of physical suffering "opened up" the mind by "opening up" the body.

> *It seems that after taking some medication, I slowly began to think openly (xiangkai, 想开). After taking medication, my body…my body let go and became open (fangkai, 放开), and then naturally my thoughts became open (xiangkai, 想开) as well.* [case 17-18-12-10, female, age 35]

> *I think the pain is related to my emotions because after being treated here, the chest pain symptoms lessened. Even though there was still a bit of pain, it lessened.* [case 10-11-12-2, male, age 52]

In this way, relationships between the mind and body were often bidirectional—emotional release could provide physical relief and vice versa. While alleviation of one set of symptoms did not always remove another set of symptoms, for some participants, the "vicious cycle" of psychological and somatic symptoms became interrupted, opening a pathway for them to "walk out."

On the other hand, many believed the most important factor in their recovery was their ability to regulate themselves. Similar to how some participants believed their own inability to cope or stop themselves from "thinking too much" explained the onset of their illness, some also believed they needed to better regulate or control themselves in order to recover.

> *For this kind of illness, the main thing is to regulate it yourself, control it yourself.* [case 21-23-12-12, female, age 57]

This idea of self-regulation was not incompatible with medical help. The following participant explained how he believed medication could help with recovery, though the ultimate key to recovery was willpower.

> *For this illness, one aspect is taking medication for treatment, but the most important thing is walking out of it on your own, overcoming the illness on your own. It's not like it can be cured and you can get better just by the doctors giving you some medicine or performing some surgery. Maybe ultimately you have to rely on your own willpower to fight the illness, and through your own treatment, walk out of it.* [case 18-3-12-10, male, age 31]

Summary and look ahead

This chapter illustrated participants' social, psychological, and somatic experiences of depression and the interrelationships between these experiences. Participants believed their interpersonal relationships, societal conditions, and individual behaviors like "thinking too much" contributed to their illness, the experience of which was marked by intertwined and mutually reinforcing psychological and somatic symptoms. These symptoms interacted

dynamically with participants' social relationships, such that participants' experiences of feeling "blocked" or "open" often mirrored their experiences of social disharmony or harmony. Like participants' explanatory models of illness, their ideas of recovery also involved a mix of social and individual factors, sometimes in tandem with medical care.

Just as participants' social relationships shaped their illness, their illness also impacted their social lives in dynamic ways. In addition to participants' experiences of illness, the meanings of their illness as determined by themselves, their family, and larger society structured how they approached their illness and how it impacted their social roles. In the next section, I discuss what meaning depression held for participants, how this meaning was often moral in nature, and how this meaning combined with participants' experiences of depression to change their relationships with others.

CHAPTER 4: MORAL EXPERIENCES OF DEPRESSION

Underlying lived experience is moral experience, or the practical engagements that define what matters most for people in their local worlds (Kleinman, 2011). In other words, moral experience is the "pursuit or preservation of fundamental lived values," which constitute what is most at stake for people in their everyday lives (Yang et al., 2014). The extent to which an individual upholds these values in their day-to-day interactions determines their moral status within their local world (Kleinman, 2011).

Chinese ethnographies and conceptual writings have described how morality in Chinese society revolves around shared values of interconnectedness and reciprocity—fulfilling the obligations of one's social relationships (Fei, 1992). Fei (1992) and Yang and Kleinman (2008) described how Chinese society is organized around networks of personal relationships that ultimately connect each person in society. An individual's inner networks are made up of family and close friends, and outer networks include people from overlapping social groups like classmates, coworkers, and friends of friends (Fei, 1992). These networks consist of interpersonal connections known as *guanxi* (关系), which are maintained by practical ties, affective feelings, and moral obligations, such as the filial duties that children have toward parents and vice versa (Jacobs, 1979; Walder, 1986; Yan, 1996). *Guanxi* is further organized around *renqing* (人情), or a system of ethics that governs the moral and emotional dynamics of social transactions (Yan, 1996). *Renqing* is built not only on the exchange of gifts and favors, but also on one's social face (*mianzi*, 面子) and moral face (*lian*, 脸) (Hwang, 1987; Yan, 2003). While *mianzi* describes one's social status, *lian* is an even deeper embodiment of one's moral status. Both *mianzi* and *lian* reflect one's reputation for upholding reciprocity norms and fulfilling social duties (Yan, 1996, 2003). Maintaining face thus represents both a moral

obligation and a practical form of competence that allows one to access and exert influence over one's social networks (Yang and Kleinman, 2008).

Moral status is thus predicated on being connected to others and fulfilling reciprocal obligations. It is upheld through interpersonal relationships in everyday life (Fei, 1992). While moral status is not equivalent to social status, the two are closely related. Moral status both comprises and depends on one's social capital, which is indicated by the size of one's network and one's ability to mobilize the collective resources of that network (Yang and Kleinman, 2008). Moral status is equated to full adult status—children are not considered fully formed morally and become "complete people" (*chengren*, 成人) by learning morality through self-cultivation and familial relationships (Stafford, 1995). In this sense, loss of moral status is also loss of full adult status, indicating an inability to fully participate in society. Because the moral status of individual network members reflects on the entire network, the "moral contamination" that comes with associating with people of low moral status contributes to a form of "social death," or the closing off of social networks for offending individuals and their families (Yan, 1996; Stafford, 1995).

While moral status retains relevance as a "core cultural orientation," social dynamics in China are being "contested and reconstructed" with modernization and globalization (Yang and Kleinman, 2008). Yan (2011) described the "changing moral landscape" in post-reform Chinese society and the sometimes contradictory coexistence of "old" values centered on collective responsibilities and "new" values emphasizing individual freedoms. As the party-state leads the Chinese public in promoting market competition and the pursuit of material prosperity, a greater importance has been given to individual happiness and self-reliance. As new values emerge and gain prominence, more traditional values have not been entirely replaced but rather preserved,

adapted, or redefined. Yan (2011) gave the example of a young woman construing her pursuit of personal happiness and material comfort as a demonstration of the traditional value of filial piety, since her parents' greatest hope and source of happiness was her happiness. Thus, even as family ties weaken, networks become more pragmatic, and social expectations adapt to societal change (Yan, 2003; Yang, 1998), *guanxi*, *renqing*, and face remain guiding principles of social and moral life in modern-day China (Yang and Kleinman, 2008).

"What matters most": Fulfilling family roles

Participants' sense of their moral status shaped their experiences of depression. What mattered most to participants was retaining their ability to fulfill reciprocal family roles. Family served as the moral core of participants' lives—they were most concerned with being a "good daughter," "good husband," "good mother," etc. Depression, as well as stigma against depression, threatened their ability to do so. Participants viewed their inability to reciprocate in their relationships and uphold their family roles as a moral failure, such that what was at stake in their illness was their ability to live by their values, and by extension, to live worthwhile lives.

Threats to moral status

In the next sections, I discuss how functional and work impairment, unaffordable mental healthcare, and perceived loss of self-control threatened participants' ability to fulfill their family roles, thereby threatening their moral status.

Functional and work impairment

Depression prevented some participants from being able to function as they used to (or as they believed they ought to), precluding them from fulfilling family obligations and preserving moral status. The impairment that resulted from depression came with its own set of moral judgments.

Participants described no longer being able to work, socialize, perform household chores, or even move while depressed.

> *Now my body can't go on anymore. I feel like I have no strength in my whole body. I lie in bed all day. I have no strength to do things.* [case 13-20-11-14, female, age 76]

> *Now after I've gotten this illness, even my job is gone, I can't do it anymore, I can't work, can't do business.* [case 10-38-12-17, male, age 53]

Impairment impacted participants in practical ways, detracting from their income, functioning, health, and quality of life. Importantly, it also impacted them in moral ways. By limiting their ability to fulfill family obligations, impairment produced feelings of guilt, shame, and worthlessness.

> *I'm incapable, I can't help do things, so I feel very irritable…To me, my body is not well, and I can't help my family, so I feel disgusted with myself, and irritated.* [case 14-2-12-13]

Impact on family roles

Impairment threatened participants' particular roles as fathers/husbands, mothers/wives, and daughters/sons. The following participant described how depression threatened his role as a father and husband.

> *I am also very worried and afraid that this illness will affect my future. I have children after all. This family has very high hopes for me, they hope that I will still do more for the family. If I myself have fallen, if I myself can't walk out, the impact on this family will be much too big. The pressure I feel is also rather a lot because I have this worry.* [case 18-3-12-10, male, age 31]

With a wife, preschool-age son, and aging parents to care for, this participant spoke of the expectations that society and his family had for him to provide for and lead the family. Being able to do so was a practical issue affecting the survival and prosperity of the family, as well as a moral issue of what a "good" husband, father, and son should do. The preservation of the participant's moral status within the family was contingent on the outcome of his treatment, or

whether his illness would continue to preclude him from fulfilling his family role in the long-term.

Ability to work also reflected on ability to contribute to the family, such that work impairment often came with strong feelings of shame and moral failure. Although the importance of work was not exclusive to men, male participants may have felt a greater degree of pressure to be the primary breadwinner for the family.

> *My trouble sleeping is due to pressure, thinking about this and that, sometimes, thinking about myself, how, after so many years, I mean (tsk) it's so shameful (*diulian, *丢脸, literally:* lose face*), very shameful (*diuren, *丢人*, literally: lose person*). For a man to have muddled along to 40 years old, and to have muddled along to become like this, isn't it shameful? Having gotten this illness, you definitely feel inferior. Right now my work is not stable, and my ability to work is very poor, my results are very average. I can't support this family. I feel like I can't support this family. This family depends on my wife, my wife's ability is stronger than mine. I feel that I'm unworthy of/I've let down (*diubuqi, *对不起) my wife.* [case 18-9-12-10, male, age 39]

Female participants also spoke of depression threatening their roles as mothers/wives, who were expected to "hold up half the sky," or shoulder half the responsibility of providing for the family's wellbeing.

> *I blame myself for not fulfilling my responsibility as a mother. (crying) People say to bring home a daughter-in-law who can hold up half the sky. I can't hold up even a bit of the sky. I'm too lazy, and my brain is no good […] I don't know why I'm so fragile, crying whenever I encounter anything.* [case 17-25-12-9, female, age 27]

The saying "women hold up half the sky" was uttered by Mao Zedong to argue that, in the new China, women could do just as much as men in the workforce (Zhong, 2011). While this was meant as an empowering statement of gender equality, in practice it often meant that women became expected to work as much as men while still maintaining their traditional responsibilities within the home (Zhong, 2011). Here, the participant indicated how "holding up half the sky" became part of her moral responsibility as a mother, wife, and daughter-in-law and how she

considered herself "lazy," "fragile," and in possession of a "no-good" brain because of her impaired ability to fulfill that responsibility.

Participants also described feeling despair and shame at their impaired ability to be filial and give back to their parents. While studies have demonstrated the weakening of filial expectations with modernization (Yan, 2003), studies have also shown that filial obligations continue to hold moral weight among young Chinese in the modern day, even as ways of exhibiting filial piety change (Hsu, 2019). The following participant described how she hoped to bring her parents happiness in return for their care for her, but her impairment prevented her from doing so.

> *I feel that [if I were to die], my mother could live more easily. (pause) I feel that my parents raised me to be this age, and now it's time for me to pay them back, but I can't do anything.* [case 21-4-12-12, female, age 20]

Moral judgments of impairment

Impairment greatly impacted participants' moral sense of self-worth and identity. Many participants spoke of feeling "useless," "weak," and "lazy."

> *This illness has changed me as a person. I've become a different person. I've become a useless person. All day I don't want to do anything, and I don't want to go out either. Tell me, do you think this kind of person still has any use? No use. At home when I'm cleaning, mopping the floor a bit, the sweat immediately comes pouring down, my clothes get all wet. Lazy. Too lazy. It's not that I'm lazy myself. It's that your body forces you to be this lazy. You see, I'm only 65 and I'm like this. I feel sorry letting my husband do it too.* [case 10-37-12-18, female, age 65]

This participants' sense of uselessness stemmed from her physical limitations, which prevented her from performing household duties and created guilt from forcing her husband to take on her usual roles.

These moral judgments of impairment as indicating "laziness" and "uselessness" overlap with stigma against disability in China. Despite the progress achieved by disability movements in

China over the last several decades, disabled people are still often viewed as a burden on society, draining society's resources without adding to it. In the social-transactional context of *guanxi* and *renqing*, disabled people are often thought of as "useless." *Canfei* (残废), a common derogatory term for disabled people, translates roughly to "waste." While depression is not included in the Chinese government's definition of psychiatric disability, which refers primarily to psychotic disorders (Kohrman, 2005), the impairment that accompanied experiences of depression prompted participants to think of themselves in terms of disability and its associated stigma. Participants' accounts of impairment showed how stigma against depression interacted with stigma against disability to threaten their moral status.

Burden of treatment for depression

Feelings of burdensomeness often accompanied feelings of uselessness. Some participants felt that, because they were depressed, they not only could not contribute to others, but also served to "make trouble for" and "burden" others, particularly because treatment for depression is costly in China. Less than 15% of China's population has health insurance that covers mental illnesses (Liu et al., 2013).

This sense of burden added to participants' feeling of failing at their family roles.

> *I feel like I don't have any use, I have always just added trouble. I think about the hospitalization fees here, and my father…I think about when he goes on a business trip, he told me before, he said in order to save money, he only eats a 1 yuan biscuit for dinner. And then, I also think about how I've gotten this kind of illness. Isn't there a name for this kind of illness called the disease of the wealthy? This kind of disease of the wealthy costs a lot of money, I just think…I haven't been a good daughter, I haven't fulfilled the role in society that I should have.* [case 22-33-12-5, female, age 18]

This participant felt that the cost of her treatment for depression impacted her "usefulness," or self-worth and role within society. She felt that the burden of her hospitalization

costs on her family reflected on her status as a "good daughter," which was the moral role she ought to fulfill.

This sense of burdensomeness may be particularly strong for rural participants. Rural patients have fewer health insurance benefits than urban patients, so the cost of treatment is higher. Rural residents in China are eligible for the New Cooperative Medical Scheme (NCMS) for health insurance, but the reimbursement ratio for mental healthcare under this scheme varies between 30 and 70%, and it does not cover healthcare outside of the province or city of residence (Xu et al., 2018). This poses particular hardship for rural residents who work in urban areas like Nanjing, and for residents of rural areas that tend to lack adequate mental health services (Zheng et al., 2018; Xu et al., 2018).

The following rural participant described her anxiety about affording treatment for depression:

> *I worry about being unable to pay the medical bills. We rural people are poor. We get little reimbursement from insurance, and being treated here for this illness is pretty expensive. I do worry about this.* [case 9-39-11-20, female, age 67]

Similarly, the following rural participant described how his guilt at bringing hardship to the family and not having money for treatment exacerbated his depression.

> *I feel a pretty large amount of pressure, I'm not getting better, I have no money. I think about it every day, and I'm unhappy every day. See, a 70-year-old person like me, getting this kind of illness, how much hardship I bring to the family* [case 14-46-12-2, male, age 71]

As such, structural factors like the high cost of mental healthcare and low reimbursement of rural health insurance contributed to participants' feelings of moral failing and added to the stress of depression.

Loss of self-control

A third major threat to participants' moral status was the threat of losing self-control. Self-control in this case meant two slightly different but related things. One aspect of self-control was self-management, or the ability to manage one's affairs and solve one's problems. Another aspect of self-control was having control over one's mind—being able to think rationally and morally. Both these aspects involve an ability to moderate and adjust one's behavior, but loss of mental control may signify a greater degree of loss of self-control.

Loss of self-control has moral implications. In Confucian thought, an individual must control themselves before having influence over others (Lau, 1984). In the context of Chinese relational networks, not being able to control or regulate the self means that an individual cannot be trusted to make appropriate moral judgments and fulfill social roles. In other words, if someone cannot solve their own problems or moderate their own behavior, then they cannot be relied upon to resolve others' problems or influence others' behavior. Not being in control of oneself relegates an individual to the position of a child who has not yet earned moral status. Their inability to reciprocate in mutually beneficial social relationships bars their participation in society as a full, moral adult (Lau, 1984).

Loss of self-management

Participants described feeling anxiety over being unable to manage themselves or being perceived as unable to manage themselves. Self-management in this case meant being able to manage their affairs and solve their own problems.

> *Now with my illness, I can't take care of personal matters. Whenever I'm ill then I can't take care of it.* [case 13-44-11-4, female, age 69]

The loss of self-management that participants felt stemmed in part from the all-consuming and debilitating nature of their suffering. They could no longer attend to their

personal affairs because they were in great pain and "fighting for their lives," as one participant said.

Often, participants' fears of losing self-management were also tied to social and cultural perceptions of depression. Participants' perceived loss of self-control derived from popular conceptions of depression as, by definition, a condition involving ineffective coping and low problem-solving ability, as the explanatory model of "thinking too much" from Chapter 3 indicated. The following participant offered inability to control one's problems as the defining feature of depression.

> *When someone is depressed, they can't face their own problems. They can't effectively solve any problems that may be there.* [case 22-13-12-5, female, age 22]

Impact on family roles

Since lack of self-control meant that one could not be a full moral adult, participants' perceived loss of self-regulation often resulted in infantilization, which undermined their position within their social networks. Since the details of diagnosis and illness were often confined to the family, participants experienced the greatest change within their family dynamics. Lack of self-management was seen as antithetical to the demands and responsibilities of reciprocal family relationships. Being depressed or mentally ill forced participants to relinquish some measure of status within the family, such that they lost decision-making ability and influence over other members of the family.

> *If it's a time when my illness is active, when I'm anxious and restless, when I can't sleep for days on end, I don't think about anything else, and during those times my family also will not let me make any decisions. The only decision is to accept treatment.* [case 18-3-12-10, male, age 31]

As a head-of-household, this participant usually served as a primary decision-maker in the family. His family members took over his decision-making role while he was ill. This could

be seen as an act of care to prevent him from straining himself and to let him focus on recovery. However, it also signified that they believed him incapable of making decisions and that it was inappropriate for him to do so while ill. As a result, the participant temporarily relinquished his role as a decision-maker and head of the household.

Lack of self-management was also seen as incompatible with the expected role of a mother, who participants believed should be a role model and problem-solver. This led participants to believe that they could not be a "good" mother while being depressed and unable to manage their own problems.

> *I just feel like a mother should be a good role model. I'm always asking what a good mother is. People all say it's someone who can solve any problem they encounter on their own. So my illness is something I will have to get over.* [case 9-17-12-16, female, age 32]

For these participants, depression precluded them from occupying their expected familial roles as decision-makers and problem-solvers. Not being able to fulfill their expected societal roles within the family came with a great deal of moral shame. For many participants, their perceived lack of self-regulation upended traditional principles of moral behavior and hierarchies of authority within the family.

> *My son is filial, he had never gotten angry at me. Yesterday when I didn't want to come to the hospital, he got angry at me. He said if you don't stay at the hospital, I won't recognize you as my mother anymore. But I'm not mad, I brought this on myself. I should have listened to my son. Now that I'm ill, I can't direct myself.* [case 14-10-11-13, female, age 66]

For this participant, the behavior of her son would have violated the moral standards of filial piety had she not been ill. However, because she was ill, she lost the privilege of self-direction. Her illness flipped the familial power structure and transformed the parameters of moral behavior.

Loss of mental control: Becoming "crazy"

A more extreme loss of self-control involved losing rational thought and moral judgment, or becoming "crazy," as participants said. Participants feared belonging to a stigmatized category of people with "*shenjingbing"* (神经病), which is a pejorative term for mental illness. People with *shenjingbing* were thought of as irrational and unpredictable and could even be dangerous (Phillips and Gao, 1999; Luo et al., 2018). Some participants believed depression was a type of *shenjingbing.* A depressed person's perceived inability to control their thoughts could be a sign that their brain is "broken" or has "gone bad" (*huai le*, 坏了) (Yu et al., 2018). Losing control over the mind involved losing moral agency, which centered around fulfilling family obligations.

For example, the following participant viewed lack of self-control as not being able to restrain herself from doing wrong, including causing harm to herself and family members.

> *My head hurt nonstop, my head was incredibly uncomfortable. I just wanted to hit my head against the wall. I was pulling my hair all day, just wanting to hit my head against the wall. I was afraid of not being able to control myself, afraid of losing control. But my brain was still clear. But I was afraid if I was truly mentally ill, I might lose control. I was afraid of hurting my children, and I was also afraid of hurting myself.* [case 17-18-12-10, female, age 35]

Although the participant felt her "brain was still clear," meaning she could think rationally, she worried she might become "truly mentally ill" and "lose control," or become unable to distinguish between right and wrong and restrain herself from harming herself and her children. The participant's fear reflected a concern with losing moral agency, or the ability to tell right from wrong, which was tied to the loss of self-control that comes with being "truly mentally ill" and reflected on her ability to be a "good" person and "good" mother. Stigmatizing ideas attached to mentally ill people's capacity for self-control and moral judgment colored the participant's actual experience of her illness and contributed to her fear of losing moral agency.

Often, participants' degree of agency and control were delimited by what others deemed them capable or deserving of having, based on their illness status. The following participant

described her son struggling to reconcile his view of his mother with his idea of depressed people as lacking mental control and therefore "crazy".

> *My son doesn't understand, he thinks depression is* shenjingbing*, it's the brain being broken, but my brain is not broken. What he means is I don't have an illness and I shouldn't stay in the hospital. He said I'm not confused, I cook when it's time to cook, I know to want to save my portion of food for my children to eat, I know to go home when it rains. My son sees me as someone who won't come home when it rains, he's classified me with the "crazy" people.* [case 9-38-12-18, female, age 66]

This participant described her son's difficulty placing her in relation to his idea of depression and its associated loss of self-control—he believed she either had control of her mind, in which case she was not ill, or she had depression, in which case her "brain was broken" and she had become "crazy." It is worth noting that the defining actions of a "crazy" person were imagined to be not just irrational (staying out in the rain), but also immoral. As a mother, the participant was expected to care for her children and put their needs above her own. A "crazy" person was imagined to lack this moral capacity. As such, loss of control over the mind was associated with not just loss of rational thought but also loss of moral judgment. Being "crazy" and losing moral agency involved an inability to participate in family life and fulfill family obligations.

Many participants described being acquainted with the stigma of mental illness, including the view of mentally ill people as dangerous to themselves and others. Some participants described facing discrimination—one participant recounted being made to leave an emergency department after the doctor learned of her depression, for fear that she would harm the other patients. Although most participants said they did not face discrimination because they did not tell people outside the family about their illness, the fear that they would be stigmatized or that they were "truly mentally ill" added to the moral threat they felt, and the ideas of family members about mental illness also served to limit participants' family roles. Many participants also shared in the view that mentally ill people lacked mental control and moral judgment before or even after they were diagnosed with depression. From

these participants' perspectives, what separated them from *shenjingbing* was only a matter of illness degree, or the degree of self-control they retained.

Negotiation of moral status

While the previous sections discussed how participants' moral status was threatened and family roles were changed, participants also played active roles in negotiating their moral status and illness roles.

Finding new ways to reciprocate

In order to preserve their moral status, some participants attempted to find new ways to reciprocate in their family relationships, despite the functional limitations that their illness posed.

> *This time that I've been ill, I feel like I'm useless, I feel like I'm no use at all. I feel like I'm like a disabled person, unable to do anything. I can't sleep. When I'm at my daughter's house, my daughter's house is big, and I get up and I feel like I have to do my work even if I have to grit my teeth. I sweep and mop, it's like this every day. I live in her house and I can't add to her burden. She needs to help take me to the hospital, so I help her with some housework. I need to help her with the housework even if I have to grit my teeth, I'm just this kind of person.* [case 14-9-12-3, female, age 62]

This participant spoke of the need she felt to reciprocate in her relationship with her daughter somehow, in order to lessen her feeling of being "useless" and "disabled." She did what she could around the house, despite the effort it cost her, to repay her daughter for caring for her while she was ill. These actions were not borne from an explicit agreement between her and her daughter. Rather, they stemmed from a personal need to assuage the guilt and shame she felt at being ill and preserve her identity as a person who values reciprocity and is capable of reciprocating in her relationships.

Asserting mental control

In the face of stigma against depression, which Yang et al. (2007) argued can be felt even if not consciously acknowledged, the anxiety of losing self-control could also be seen through participants' desire to assert agency and cognitive control.

> *My spirit (jingshen, 精神) is healthy, my spirit is good. There are no problems with any aspect of my thinking.* [case 10-16-12-17, male, age 37]

This participant aligned his thinking with his spirit, insisting that his illness lay outside this domain and thus attempting to preserve his personal agency. Similarly, a participant mentioned earlier asserted mental control by saying her "brain was still clear."

Some participants also tried to protect their moral status by denying they were depressed at all, even though they had been referred to the inpatient psychiatric unit by other doctors or been brought there by family. They believed they could not "truly" be depressed because they retained their self-control and cognitive capacities.

> *I don't think I actually have true depression. I feel like I can control myself very well. True depression is extreme dejection, and then (pause) not being able to find effective solutions, and then also having suicidal impulses.* [case 22-13-12-5, female, age 22]

> *At first, I refused to come here. My daughter said you're not okay like this, you make us restless all day. Your body is getting worse and worse, you don't have enough energy, so they sent me here. At the time I refused to come, I felt like my head was clear and I understood everything, I just couldn't sleep.* [case 14-9-12-3, female, age 62]

These participants associated depression with lacking self-control and not thinking rationally. They resisted being diagnosed and treated for depression because it would call into question their degree of self-control, particularly mental control, and threaten their moral status.

Summary and look ahead

This chapter identified what was at stake in participants' experiences of illness—what mattered most to participants was maintaining their roles as moral persons within the family, and the impairment and stigma of depression, as well as the cost of mental healthcare, threatened

participants' "moral status" and familial roles. Functional and work impairment impacted participants' ability to fulfill family obligations and reciprocate in their relationships, and the threat of losing self-control (both the ability to manage one's affairs and the ability to control one's mind) reflected on participants' moral agency and place within the family. Participants' moral concerns grappled with stigma against depression, mental illness, and disability. As participants experienced changes in their family lives as a result of illness, they also actively negotiated their moral status by finding new ways to reciprocate in their relationships and asserting their control over their mind.

Another way that participants attempted to preserve moral status and assert self-control was by emphasizing and focusing attention on their somatic symptoms. In the next chapter, I take a closer look at why participants tended to emphasize somatic symptoms, how this somatic emphasis was related to participants' moral experiences of illness, and what uses this emphasis served in participants' relationships and medical help-seeking.

CHAPTER 5: SOMATIC SYMPTOMS IN EXPERIENCES OF DEPRESSION

Chapter 3 discussed how participants described interwoven relationships between their mind and body and experienced symptoms that had both psychological and somatic components. For example, a symptom like "heart swollenness" (*xinzhang,* 心胀), which many participants claimed as a chief complaint, could be related to mood and also feel like physical pain, making it difficult to categorize as a "psychological" or "somatic" symptom. In addition, participants typically described a mix of symptoms that affected their emotions, thoughts, behaviors, and physical sensations, such that very few participants attested to a strictly "somatic" or "psychological" symptom profile in the course of their narratives.

However, participants did tend to emphasize the somatic nature of their experiences and select largely somatic symptoms as their chief complaints, as shown in Table 2. For example, a 20-year-old woman, who described experiencing a multitude of psychological and somatic symptoms and understood her diagnosis of depression to mean "being unhappy," said she wanted to have her headaches treated and nothing else.

In addition, many participants initially believed that they suffered from a physical illness, leading them to seek medical help from specialties like cardiology and neurology before eventually arriving at a psychiatric care facility. This pattern of help-seeking often delayed needed treatment and sometimes resulted in inappropriate treatment, exacerbating participants' symptoms and worsening their health.

As such, though participants' narratives demonstrated that their symptoms often defied simple classification as "somatic" or "psychological," participants constantly made conscious or unconscious choices about how to understand and present the nature and origin of their

symptoms. Such choices were important in that they influenced participants' help-seeking behavior and affected the course of their illness.

Explanations for "Chinese somatization"

Participants' emphasis on somatic experience supports prior studies on Chinese depressed patients' symptom presentation. In 1977, Kleinman coined the term "Chinese somatization," after observing that Chinese outpatients who qualified for a depression diagnosis presented predominantly or exclusively somatic symptoms, unlike typical "Western" patients who focused on psychological symptoms. Many subsequent cross-cultural studies have affirmed Kleinman's observation, even as emotional expression became more politically acceptable and awareness of depression grew in China (Yen, Robins, and Lin, 2000; Parker, Cheah, and Roy, 2001; Ryder et al., 2008). Later studies have also pointed out the "inherently comparative" nature of the term "Chinese somatization" and noted that somatic presentation of psychological distress has been commonly observed across the world, making it perhaps more appropriate to speak of "Western psychologization" instead (Ryder and Chentsova-Dutton, 2012). Nevertheless, Kleinman's initial study has sparked decades of debate around explanations for "Chinese somatization" and its implications for understanding the role of culture in mental health.

Earlier explanations have mostly differed on whether somatization reflects cultural variation in the experience of illness or in the expression of illness. In other words, does culture affect how people experience depression on a symptomatic level, or does it only affect how people communicate their depression to others (Cheung and Lau, 1982; Simon et al., 1999)?

More recent theories have posited that the two explanations are not mutually exclusive, claiming that culture affects both the experience and expression of illness. Ryder and Chentsova-Dutton (2012) proposed an attentional explanation of somatization—people in distress

experience an incoherent mix of symptoms, and the cultural context shapes how people interpret and communicate those symptoms. As some symptoms are perceived to be more culturally salient than others, the attentional focus amplifies or diminishes people's experience of certain symptoms, thereby affecting their experience of illness.

While it is not possible to definitively discern participants' experiences based on interviews alone, participants' narratives seem to support the idea that they experienced a mix of psychological and somatic symptoms, placed attentional emphasis on somatic symptoms, and genuinely experienced somatic symptoms as more salient and central to their illness, as will be discussed further in this chapter.

This attentional explanation of somatization still leaves open the question of why participants paid more attention to somatic symptoms, or why somatic symptoms were perceived as more salient than psychological symptoms.

This chapter discusses how participants' narratives revealed an underlying expectation that psychological symptoms should be self-regulated, stemming from cultural beliefs about the value of mental self-control (Lau, 1984). Participants' ability to regulate their psychological symptoms posed moral implications for their capacity for self-control. Participants attempted to navigate these moral implications by focusing attention on their physical symptoms and identifying physical symptoms as the root cause of their psychological distress. The moral meaning attached to self-control of the mind affected how participants experienced their symptoms, how they presented their symptoms to others, and how they sought relief from their symptoms.

Somatic symptoms and mental control

Some participants' explanations for emphasizing certain symptoms over others demonstrated their belief that psychological symptoms could be self-regulated while physical symptoms could not. For instance, both of the following participants described experiencing psychological and somatic symptoms, but they desired medical help for poor sleep only, which they believed prevented them from handling their psychological symptoms on their own.

> *It's not emotional suffering, emotions can be regulated. For example, if my husband didn't want me anymore, I would definitely suffer, but I could walk out of it. If I were able to sleep, I could definitely walk out of it. […] My suffering is suffering from physical feelings.* [case 22-6-12-5, female, age 42]

> *Depression and stress, these things are definitely there, and I definitely can't get rid of them now. But once I sleep well, to me that stress will be within a range that I can normally bear, so actually what is more urgent for me is solving my problem with sleep. This is what I need at present. And then regarding the common symptoms of depression, I think that after my sleep is better, everything else will gradually get better as I slowly adjust my own mentality (*xintai, *心态).* [case 10-40-12-3, male, age 36]

These participants insisted that they could control their psychological symptoms if physical symptoms were not present. This could be related to participants' explanatory models of illness—if they believed somatic symptoms to be the cause of their illness, they understandably believed their treatment should target the source of their illness.

However, their insistence that they could control their psychological symptoms contained a normative component as well. Some participants who felt they could not control their psychological symptoms nevertheless expressed the belief that they *should* control them.

> *I don't really understand depression. I only know that when someone is at a weak point, they won't be able to think openly and they'll do some foolish things. But I also know I have to control my mood. But when you're in the midst of the illness, it really is very hard to control.* [case 9-32-12-20, female, age 34]

In this way, participants' narratives often revealed an underlying cultural expectation that the mind should be controlled, more so than the body, which may lie outside of individual control. In the previous chapter, I discussed the moral implications of lacking self-control in the

Chinese cultural context—not being able to control or regulate the self means that an individual cannot be relied upon to make moral judgments and reciprocate in mutually beneficial social relationships (Yang and Kleinman, 2008; Lau, 1984). Many illnesses seem to be widely accepted to lie outside of individual control and therefore carry less moral blame in modern-day China—for example, many participants said there was no shame associated with catching a cold. However, the cultural expectation that the mind should be self-regulated means that the psychological symptoms of depression often reflect on an individual's degree of self-control and consequently the individual's moral status.

This is not to say that participants' physical symptoms carried no moral weight. The physical impairment that often accompanied participants' illness caused them shame and guilt as it prevented them from reciprocating in their relationships as they felt they should. However, psychological symptoms carried an additional layer of moral meaning because of the centrality of thoughts and emotions to the "self" and to personal agency.

Somatic symptoms and avoiding stigma

The moral meaning of psychological symptoms could be seen through participants' concerns about how other people would respond to their illness, as well as their experiences of negative responses from friends and family.

Stigma of psychological symptoms: Lazy-crazy dichotomy

Participants tended to worry about others responding to their illness in one of two ways: by saying they should "think out of it" or by saying they were "crazy."

The following participant's description of how her friends viewed her depression illustrates both these responses.

> *Before I became ill, I felt quite proud of myself because I had many good friends by my side. If I was in trouble, even if I hadn't said anything, they would all know and come to*

> *my aid. I had a group of friends I could open my heart to. But after I became ill, all these feelings went away. People couldn't understand me. […] My friends would all say, you're well-off, even if you didn't work, you would still live well. Why are you looking for ways to make yourself unhappy? What can you not think openly about? They think it's very surprising and will often criticize me for it and tell me not to take medication. I just feel like after taking medication, I will be able to sleep, and then maybe I won't be so tired and irritated, and my body won't feel so uncomfortable. Also, because of my illness, one of my very close friends stopped talking to me. She just felt like I was crazy (shenjingbing, 神经病).* [case 9-32-12-20, female, age 34]

Her friends' reactions revolved around a central issue of self-control of the mind. Those friends who felt the participant possessed full control of her thoughts and emotions criticized her for creating problems for herself and relying on medication. The friend who believed the participant was "crazy" seemed to think the participant had lost control of her mind. Notably, to justify her use of medication, the participant emphasized that the medication's purpose was to help her with a physical symptom, poor sleep, from which she believed her other symptoms arose.

Participants whose family and friends believed they could control their psychological symptoms often faced being seen as "lazy" (懒, *lan*,) or "idle" (闲, *xian).* Participants described feeling frustrated and misunderstood by being told to "think openly" or "think out of" their psychological symptoms (想开, *xiangkai)* when they felt such symptoms were beyond their control.

> *My family doesn't understand my illness. They think it's just because I'm thinking too much about nothing. They all say this illness (tsk)… is just me (tsk)… they think this illness is entirely something I can control.* [case 21-15-12-20, female, age 19]

Such responses by friends and family served to invalidate participants' suffering and implied a degree of moral blame—if others believed participants had full control of their symptoms, that would imply that they believed participants chose to shirk responsibilities,

withdraw from relationships, and create burdens for others, rather than believing that illness had engendered these consequences.

On the other hand, if participants were understood to be incapable of controlling their psychological symptoms, they risked others thinking something was wrong with them as a person.

> *I'm worried what other people would think. Maybe they would say it's your own problem that you can't think out of it, there's something wrong with you yourself, things like that.* [case 10-24-12-17, female, age 68]

Participants also worried that, on the more extreme end, they would be seen as having lost control of their mind entirely and be considered "crazy." As discussed in Chapter 4, being considered "crazy" would preclude them participating in society as full persons who were capable of moral judgment, causing them to potentially lose social relationships and become barred from fulfilling their family roles.

Participants faced this balancing act between being seen as "lazy" and being seen as "crazy" when they discussed their diagnosis or their psychological symptoms. Given the cultural expectation that the mind should be self-regulated, the idea of depression as an illness of the mind and of psychological symptoms as problems with the mind threatened participants' self-control and moral identity in a way that physical symptoms did not. Perhaps for this reason, participants tended to focus attention on their physical symptoms both in their personal conceptions of their illness (as narrated in interviews) and in their presentations of their illness to others.

Presentation of illness to others

In part because of the stigma involved, participants tended to only discuss their illness with close family. Many were reluctant to share too much personal information in general with

acquaintances. But when participants did discuss their illness with friends, coworkers, and relatives who were not close family, they often focused on somatic symptoms.

For example, many participants who described a range of symptoms in their interviews said they only told others they had stomach aches or headaches or poor sleep. These participants described being wary of the stigma of depression and how others might understand their symptoms.

> *I have to be worried [about telling people I have depression], other people will say my personality is not good. And the word might spread. I won't even tell people that I'm staying at the Brain Hospital. Last time when I was leaving here after an inpatient stay, I was seen by some relatives. I just said my nerves hurt, and they kept asking me about it for a month.* [case 22-17-12-5, female, age 52]

When asked what it meant for her nerves to hurt, the participant said, "Maybe just that the muscles in your body hurt." In front of her relatives, the participant attempted to avoid the stigma associated with having psychological problems by naming a physical affliction. In this case, she was limited to what might be treated at the Nanjing Brain Hospital, which sees patients with psychiatric and neurological illnesses.

Like this participant, many participants attempted to avoid the moral implications and stigmatizing misunderstandings attached to psychological issues by avoiding mention of psychological symptoms altogether. Other participants did mention psychological problems to others but emphasized that these issues were in reaction to their primary somatic complaints.

> *I don't [tell other people I have depression], other people don't understand. Usually when I'm with other people, they also can't tell I have problems. I only tell them my sleep is not good, so my mood is not good.* [case 10-30-12-17, male, age 62]

In such cases, somatic symptoms like poor sleep seemed to serve as understandable justification for psychological symptoms like low mood. The participant's low mood was

understood to be a reasonable reaction to a physical affliction that was outside of his control. Another participant expressed a similar sentiment:

> *I can't sleep the entire night, which is why I'm suffering so much. Anyone who has undergone my suffering would have a few problems with their spirit (*jingshen, *精神), too. The fact that I've been able to survive to this day…and haven't gotten schizophrenia, or something, is already quite good, it means my heart-mind is already very strong.* [case 22-6-12-5, female, age 42]

This participant believed the suffering associated with poor sleep would naturally lead to mental illness. This belief allowed her to defend herself against the stigma of depression by insisting on her mental strength and self-control—she explained that she actually exercised great control over her mind in order to resist the natural progression from sleep-related suffering to schizophrenia, which she believed lay on the more severe end of a spectrum with depression. Her attempt to preserve moral status in this way implies a mutual understanding that psychological distress is less stigmatized if seen as a reasonable response to physical suffering—in other words, if the underlying illness is an uncontrolled physical symptom rather than an uncontrolled psychological symptom.

Many studies have posited avoidance of stigma as a reason for somatization in China and other countries (Goldberg and Bridges, 1988; Raguram et al., 1996; Barney et al., 2006). This avoidance could be a conscious choice, as when people decide how to discuss their illness with friends, and an unconscious attentional bias that affects people's experiences of their symptoms. In other words, even if people are not actively trying to avoid stigma, pervasive cultural beliefs may provide a "script" that influences how they make sense of their experiences, what symptoms they focus on, and in turn how they experience those symptoms (Ryder and Chentsova-Dutton, 2012).

The prevailing cultural script considers somatic symptoms to be legitimate sources of distress, while psychological experiences should be under the control of moral persons. Because participants' attention was drawn to somatic symptoms as indicators of illness, the experience of these somatic symptoms may have become more salient as well. This salience of somatic symptoms was reflected in participants' help-seeking decisions as well.

Somatic symptoms and medical help-seeking

Because participants' attention was drawn to physical symptoms, they often believed they suffered from physical illnesses and sought treatment initially from emergency rooms and non-psychiatric specialists. Participants' emphasis on somatic experiences affected where and when they sought professional help. Somatic symptoms were often what drove participants to seek medical attention. The following participants described feeling sad and worried for many months and not believing they were ill until they began experiencing changes to their physical state:

> *At first, I didn't know I was ill. Then when I couldn't sleep, and I got thinner, thinner, thinner, then I felt like I had become ill.* [case 10-23-12-19, female, age 52]

> *I was just at home crying, crying, and only when it hurt here (points to chest), only then did I think to get treatment. Treatment for heart disease.* [case 10-37-12-18, female, age 69]

While somatic symptoms drove participants to seek help when they otherwise would not, they often faced a long and frustrating process. Participants were often told there was nothing wrong with them and in some cases were treated for illnesses they did not have—the above 69-year-old participant described being inappropriately treated for heart disease and "almost dying" from using heart medication.

This pattern of somatic help-seeking may reflect a lack of awareness of depression. Many participants, particularly older and rural participants, described not having heard of depression before being diagnosed with it. Some participants described having been aware of depression but

not realizing that it applied to their symptoms, possibly indicating a narrow popular conception of depression as a psychological illness.

However, some participants also demonstrated a strong reluctance to seek psychiatric help even after being referred to psychiatric care, suggesting that there was more to their somatic focus than a lack of awareness of depression. The following participant described enduring a torturous process of ineffective help-seeking, involving considerable tests, hospital visits, time, suffering, and money, before finally turning to psychiatric care as a last resort.

> *Previously, doctors had told me to visit a specialist [psychiatric] hospital, thinking the doctors there would have more advanced diagnostic tools. I always held out hope, thinking I wouldn't need to go, and I could just get better there. I didn't expect that I wouldn't get better, and I would even get worse. Then I became desperate—they couldn't figure out the cause, and I had nowhere to go for treatment. As long as I had any hope, I definitely would not have wanted to come here. It was only when I became deeply desperate, when I had no other way, and felt that I was doomed.* [case 14-9-12-19, female, age 68]

For this participant, somatic symptoms ironically served as a form of hope—that she had a treatable physical illness, rather than a psychiatric illness that she felt was equivalent to being "doomed." This reluctance to seek psychiatric care, despite detriment to health and wellbeing, demonstrates the powerful influence of stigma and beliefs regarding the meaning of mental illnesses.

These beliefs continued to affect participants' desires for treatment even after they sought psychiatric care. As mentioned before, many participants wanted medical intervention for physical symptoms only, preferring to handle the psychological symptoms on their own. In doing so, they sought relief for their suffering while still attempting to preserve moral status by asserting control over their mind.

At the same time, while participants' experiences of symptoms may have been influenced by cultural scripts and attentional biases, this does not mean participants did not genuinely

experience somatic symptoms or that the somatic symptoms were purely psychological in origin. In fact, the invalidation that participants felt when told their somatic symptoms were psychological and their repeated help-seeking for physical care, despite the substantial burden of medical help-seeking, points not only to the influence of stigma around psychological symptoms, but also to how central somatic symptoms were to participants' experiences of illness:

> *A lot of doctors have told me directly that they don't know what my illness is and it's just me being anxious. This might be true. But what makes them think they can say I'm just an anxious person? If I'm just anxious, why would I go to the hospital to do all sorts of tests, CT scans, blood draws, everything? […] Also, seeing the doctor, you know, is very troublesome. Every time I visit the hospital, it takes a whole day to do the tests, and often there are no results at all. Really, I have to start fasting before dawn […] and the blood draws…every hospital visit is very painful, it's unbearable.* [case 14-9-12-19, female, age 68]

Previous studies have theorized that somatization is a strategy for obtaining healthcare—patients describe the symptoms they believe are relevant to a medical setting and which will get them healthcare (Cheung and Lau, 1982; Simon et al., 1999). Participants did tend to initially believe that they suffered from physical illnesses and seek physical healthcare. However, participants' emphasis on somatic symptoms even in a psychiatric setting, following futile attempts to find relief through physical healthcare, suggests that their beliefs about their illness extended beyond a strategy for obtaining healthcare. Their desires for treatment did influence their somatic emphasis, but their desires for treatment also reflected deep cultural beliefs that existed independently of situational variables related to the medical setting.

Summary and look ahead

This study builds on previous studies by showing how cultural beliefs and moral meanings attached to the mind, body, and self-control influenced how participants understood and experienced their symptoms. These understandings affected how participants navigated stigma and determined what was relevant to a medical setting. The responses of friends, family,

and medical professionals to their symptom presentations in turn reinforced a cultural "script" for understanding and communicating their symptoms (Ryder and Chentsova-Dutton, 2012). While culture may have played a role in participants' emphasis on somatic symptoms, this does not invalidate participants' experiences of somatic suffering or their desire to seek treatment for them.

While some participants attempted to preserve moral status by emphasizing somatic symptoms and asserting their control over psychological symptoms, many participants also described the limitations of doing so. These participants did not feel like they could control their psychological symptoms and did not feel that somatic suffering adequately encompassed their experience of illness.

The misunderstanding and stigmatizing responses of others to their psychological symptoms, combined with their own beliefs about the moral meaning attached to their symptoms, contributed to suicidal behavior, as will be discussed in the next chapter.

CHAPTER 6: SUICIDALITY IN THE CONTEXT OF DEPRESSION

Now that the previous chapters have established an understanding of experiences of depression among participants, this chapter will examine how those experiences related to participants' suicidal behavior.

Participants' suicidal behavior

Ninety-seven participants (68%) reported having had thoughts about wanting to die by suicide. Thirty participants (21%) stated that they had had thoughts about wanting to die by suicide but had not thought of any methods nor taken any steps to prepare for an attempt. Thirty-eight participants (27%) stated that they had thought about specific methods but had not attempted suicide, and 9 participants (6%) reported having taken preparation steps like procuring materials or writing a suicide note without going through with an attempt.

Twenty-eight participants (20%) reported having ever attempted suicide. Five participants (4%) reporting having attempted suicide multiple times. Methods included drowning in a river, jumping from a tall building, overdosing on medication, hanging, and cutting wrists. Participants who had attempted suicide were discovered during or after the attempt by bystanders or family members and sent to the hospital.

For reference, in their meta-analysis of eight studies published before 2014, Cao et al. (2015) estimated the pooled prevalence of lifetime suicidal ideation and suicide attempts in China to be 3.9% and 0.8%. The World Health Organization (2019) estimated China's completed suicide rate to be 9.7 per 100,000 in 2016. Studies on the proportion of Chinese people who died by suicide who had a mental illness have produced varying results, mostly ranging between 30 and 70% (Law and Liu, 2008; Phillips et al., 2002b; Wu, 2011; Lee, 2011).

Table 3. Participants' suicidal behavior

Behavior	Participants	%
No suicidal thoughts	45	32%
Suicidal thoughts, no preparation*	30	21%
Preparation*, no suicide attempt	39	27%
One suicide attempt	23	16%
Multiple suicide attempts	5	4%
Total	**142**	**100%**

*Preparation included thinking of a specific method or plan for suicide, writing a suicide note, procuring materials for an attempt, etc.

Perspectives on suicidal behavior

Before discussing participants' motivations for suicidal behavior, it may be helpful to foreground that discussion with participants' perspectives on suicide, including their descriptions of how others reacted to their suicidal behavior. Participants generally agreed that suicide was "bad" and should not be done—rather, for those participants who described engaging in suicidal behavior, suicide represented a path they would take when they had no other choice to escape suffering or be a moral person. Participants elaborated on why they and others believed suicide was bad.

Associated with depression

Many participants talked about how they and people they knew associated suicide with depression. This added to the stigma of depression by reinforcing the idea that people with depression might act dangerously by harming themselves.

> *Everyone understands depression to mean you might commit suicide or something like that.* [case 9-7-11-27, female, age 37]

> *I won't tell anyone that I have depression. People think that depression means you have suicidal tendencies and it's very hard to get better.* [case 9-22-12-16, male, age 18]

The association of suicide with depression may be attributed in part to media coverage of suicide. Some participants described how the news and popular discourse influenced their ideas of depression and suicide.

> *I don't have much of an understanding of what depression is. I have only heard on the news so-and-so got depression, jumped from a building, and so on. Like I see so-and-so jumped from a building—how did they die? Got depression and killed themselves. Other than that, I don't know too much, because we don't really pay attention to this topic, this illness.* [case 9-6-12-16, female, age 48]

Result of thinking too much and not thinking clearly

Suicide may have been understood to be related to depression because both represented an inability to think clearly and cope with stress. Suicide signified a quintessential inability to think openly and clearly. Being unable to think openly means someone is taking things too hard and unable to cope with daily stressors, which could drive someone to not think clearly. Being unable to think clearly means someone is irrational and not in control of their mind. Suicide was seen as the extreme outcome of thinking too much and represented the ultimate irrational act. The following participant indicated how his suicidal ideation was the definitive sign that he was not thinking clearly.

> *My head is not clear, I even want to commit suicide, how could my head be clear?* [case 10-38-12-17, male, age 53]

Because of this association of suicide with thinking too much and thinking irrationally, some participants described how their family members considered them "fragile" or irrational for their suicidal behavior.

> *[After I told my family I had suicidal thoughts,] they reacted by just berating me. They berated me for thinking about nonsense.* [case 17-28-12-10, female, age 60]

> *[My sister] said I'm too fragile, can't think openly. Other people will think I'm pretentious and putting on airs, so I've never told anyone.* [case 22-33-12-5, female, age 18]

Because suicidal behavior was tied to a lack of self-control, it could bring shame to participants and their families. While participants' family members may have criticized their suicidal behavior as a way of protecting them through discouraging them from attempting suicide, their criticism contained an element of moral censure as well.

Notably, while a few participants believed their suicidal behavior stemmed from an inability to think openly or clearly, most participants did not identify this to be a driver of their suicidal behavior. Rather, they believed they had rational reasons for engaging in suicidal behavior, which will be discussed further in the chapter.

Irresponsible

Suicide was also thought of as immoral because it represented an abandonment of family obligations. While some participants had family members relying on them for care and support, participants who were not supporting family members still had the obligation of being part of a family and contributing to the family's overall happiness. In this way, suicide was seen as a contradiction of filial piety—by taking their own life, a child was understood to be throwing away their parents' love, happiness, and family and eschewing all familial obligations (Zou, Tang, and Bie, 2021).

As such, suicidal behavior was considered to be irresponsible and shameful.

> *When I left home and attempted suicide by cutting my wrists, everyone criticized me, said I have no sense of responsibility.* [case 17-49-12-11, female, age 22]

Ironically, both the stigma of suicide and participants' reasons for suicide arose from many of the same moral values, as will be discussed next.

Motivations for suicidal behavior

Unbearable suffering from depression symptoms

Participants most often cited unbearable suffering from depression symptoms as the impetus for their suicidal behavior. They described how the symptoms they experienced made living more painful than dying. For many participants, the intensity of this suffering drove out all other considerations, such that they could only think about how they could end this suffering.

> *The suffering is like an indescribable feeling, it's suffering in the whole body. The entire body feels uncomfortable, like you're getting sick. […] Those days [before coming to the hospital], every day from morning until night, there was not a single good moment, nor a single good part of my body. I was thinking of just one thing, I only wanted to end it. During that pain and suffering, I didn't think about anyone, not my husband, not even my grandchildren, I didn't want any money, I didn't want anything anymore.* [case 9-39-11-20, female, age 67]

> *Because it was extremely unbearable, being tortured by the illness. My head hurt, hurt too much, hurt to the point of death, I felt like I was about to die and could not get better. I thought, how could I end my suffering?* [case 17-18-12-10, female, age 35]

While some participants implicated suffering from psychological experiences—like low mood, anxiety, and emotional numbness—many participants described the particular role that somatic suffering played in their suicidal behavior.

> *For eight or nine consecutive days, I couldn't sleep, so I felt terrible, depressed, at that time I also did not want to live. Any normal person would typically be unable to handle it after two or three days, for me it was eight or nine days, so finally I became depressed. Even if you weren't depressed before, you would become depressed after that, right? I had suicidal thoughts because of the symptoms, the suffering, not because I was depressed, but because the feeling of head swollenness, wow, that kind of feeling, is truly unbearable, unbearable to the point of death, I'm telling you.* [case 9-6-12-16, female, age 48]

The participant insisted that it was not "depression" that drove her suicidal thoughts, but the amount of suffering she experienced from her symptoms, particularly the symptom of "head swollenness." She seemed to be attempting to justify her depression and suicidal thoughts by showing how they were understandable reactions to the suffering she endured, rather than entirely irrational, similar to participants who emphasized somatic symptoms as the cause of their suffering in Chapter 5.

Suicidal thoughts that were driven by suffering from symptoms usually waxed and waned with the symptoms themselves. Since most symptoms were not constantly experienced, participants who named "unbearable suffering" as the only reason for their suicidal behavior tended to attest to only momentary desires to die by suicide.

The following participant told his wife to get pills for him to die by suicide while he was suffering from "unbearable pain," which included whole-body discomfort, stomach swollenness and heat, heart swollenness and discomfort (like a cat was scratching inside of it), and head swollenness. After the moment had passed, he told her he was only joking. In this way, communicating suicidal thoughts functioned to communicate distress, in addition to reflecting a real, albeit momentary, desire to die.

> *When I'm suffering, then I want to die. When the moment is gone, I don't think about it anymore. When my heart is constantly in unbearable pain, it's no better than death, but after a while when I feel much better, then I don't want to die anymore.* [case 14-46-12-2, male, age 71]

While suicidal thoughts due to unbearable suffering could be fleeting, this suffering often triggered participants' first thoughts of suicide and interacted with other motivations for suicidal behavior.

Feeling useless: Moral implications of impairment

Moral status also played a central role in participants' motivations for suicidal behavior. A common reason for suicidal behavior was feeling "useless" or "worthless" due to experiencing impairment from depression. Unable to contribute to their family's wellbeing, participants felt like they had lost what mattered most in their lives and did not wish to continue living.

> *I just feel like there's no point to life. I think in my heart, I feel like, as I am now, I've become a waste of a person. And then, if I rely on other people for everything, then I wouldn't be me anymore. I feel very bad. I'm a person who likes doing things, likes helping others. Now that I'm ill, I can't do anything. Suddenly, I've become this way, the*

> *contrast is incredible, and it's not getting better with treatment. I just feel like there's nowhere left to go.* [case 14-9-12-19, female, age 68]

This feeling of uselessness affected participants' sense of identity and personhood, as discussed in Chapter 4. The above participant said that she was a "waste of person" and that she would not be herself anymore if she solely relied on others and was unable to reciprocate. The following participant also felt like she had no worth as a person because she could not contribute to others. This sense of having no worth or value referred to participants' perceived inability to live a moral life, which led them to not want to live at all.

> *I feel like I really have no value, I always feel like my life has no value, because I can't bring happiness to others.* [case 22-29-12-6, female, age 19]

Inability to work added to this sense of uselessness and contributed to suicidal behavior. While some participants may not have needed to work to support the family (and indeed some participants said their family members asked them not to work for the sake of their health), ability to work held implications for their self-worth, personhood, and ability to live a moral life.

> *I constantly want to die by suicide, I just feel like I can't work anymore, I hurt here, itch there, my whole body feels uncomfortable, I just think I might as well die by suicide….my legs can't walk, I've become a waste. I can't even work anymore.* [case 22-17-12-5, female, age 52]

> *I have no use now that I'm ill. I can't do things, can't drive the tractor anymore…I want to die. I'm beyond saving. I'm not a person anymore, I only have one breath of air left. I'm ill, so I should have died a long time ago.* [case 13-22-11-18, female, age 67]

As such, suicidal behavior was closely attached to moral status. Participants' ideas of worth and meaning in life were tied to their social role, and the limiting of this role by impairment or stigma contributed to suicidal behavior by making them they see their lives as unworthy of living.

Feeling like a burden: Cost of mental healthcare

Some participants felt it would actually be a moral decision to die by suicide so as not to burden or "make trouble for" their family.

> *I constantly make trouble for my parents. Even though if they lost me, it would temporarily be very painful, later on there would be no one to make trouble for them. I also have a younger sister, she's very good and obedient. I feel like there would be no one else to make trouble for them, and they will be a bit happier.* [case 17-49-12-11, female, age 22]

The following participant described attempting to strangle herself to lessen the family's burden, which she believed her illness added to.

> *I just worry that I won't get better, that my husband and my children will be burdened because of me. I feel very guilty.* [case 9-39-11-20, female, age 67]

The unaffordability of mental healthcare was a strong factor in participants' sense of being a burden, particularly for rural participants, who were poorer than urban participants and had less health insurance coverage. Faced with an illness understood to be chronic, unknown, or hard-to-treat, some rural residents may opt to die rather than burden their families with high healthcare costs (Jia et al., 2014). While this situation was not unique to depression, depression was understood to be particularly costly and hard-to-treat.

The following rural participant said his health insurance covered 30% of healthcare costs. He described how it was common for sick rural residents to wait to die rather than burden their family with paying for treatment.

> *Of course I can't afford to pay [for treatment]. For some illnesses, if the cause can't be found, then we [rural residents] don't see the doctor anymore, and wait to die. The cost of treatment is still pretty high. We often see people get cancer and not see the doctor, just go home and wait to die. We don't have urban health insurance like urban workers. We don't have health insurance, we can't afford treatment for big illnesses.* [case 13-11-11-6, male, age 69]

Like dying in response to perceived uselessness, dying to avoid burdening others stemmed from moral values surrounding reciprocity and the good of the family. At the same

time, structural factors like rural-urban inequality, high cost of mental healthcare, and inadequate health insurance influenced and constrained these moral considerations.

Feeling lonely and misunderstood: Stigma of depression

Participants also described suicidal behavior resulting from feeling lonely and misunderstood, particularly by family members. Family members' inability to understand participants' feelings and illness invalidated their suffering and prevented them from releasing their negative feelings. This sense of isolation exacerbated their suffering and produced suicidal thoughts.

> *When you get depression, you need to let it out somehow. If you don't let it out, you'll suffer. If your family members don't understand, then your suffering will multiply, and you'll want to die.* [case 21-7-12-20, female, age 19]

> *My family members don't care for me, and no one understands me. Right now, there are a lot of things that I have no way of telling others. And I really wish there was someone who understood me, whom I can tell them what's in my heart, maybe then my heart would feel a little better. But because there's no one I can confide in, because there's no outlet for me to vent, I always suppress everything in my heart, and just like dust, it keeps accumulating. There is always a point where you can't take it anymore.* [case 9-32-12-20, female, age 34]

Sometimes, family members' moral judgments of participants added to their loneliness and suicidal thoughts. These judgments often arose from a misunderstanding or lack of understanding of depression, combined with moral values around contributing to the family.

> *Life is too tiresome. Because my husband doesn't understand what I'm going through. He always thinks I'm lazy, lying in bed day and night. I muster up all my effort to do what I have to, and then I just lie in bed. He thinks I'm incredibly lazy, and I feel like life is tiresome. I thought a lot about how I could die a decent death, and of course, I could never come up with a decent way to die.* [case 10-15-12-17, female, age 67]

Loneliness can be separate from family support—some participants described their family as supportive and caring while still feeling lonely and misunderstood. Families often expressed care by taking participants to the hospital, taking care of their daily needs, visiting and

calling them, and bringing them food, even if they did not understand or were critical of what participants were going through. As a result, family members' care was often a separate matter from their understanding or moral judgments of participants, and similarly, participants' sense of being lonely and misunderstood could also be separate from how caring they thought their family members to be.

Feeling hopeless for a "cure": Role of chronic illness and medical help-seeking

Participants' suicidal thoughts from suffering and impairment were compounded by feelings of hopelessness, namely a lack of hope that their depression would get better. For many participants, their willingness to live hinged on whether their depression could get better with treatment.

> *I feel like if this illness can be cured, that is, my current down, depressed state, then I should feel hopeful for my future life. I'm only 22 years old, I've just started working. But if my illness drags on and can't be cured, then I feel like there's no hope for the future.* [case 17-49-12-11]

Some participants reported having had suicidal behavior when they were experiencing symptoms but did not yet know their diagnosis. Their suicidal ideation resulted from not knowing the nature of their illness and not knowing if it could be treated.

Unsuccessful help-seeking played a large role in this experience. Participants described how their suicidal behavior arose or was exacerbated when doctors told them their illness was unidentifiable or nonexistent.

> *The most important reason [for my suicidal thoughts] was I felt like there was no way to cure this illness. It was unresolved, they [the doctors] couldn't find what was wrong.* [case 14-9-12-19, female, age 68]

> *Later on, I also did a scan, and they said I didn't have any problem and told me to return home. When I returned home, I couldn't even walk, I couldn't go on anymore.* [case 10-37-12-18, female, age 69]

When participants were told that doctors could not help them, they felt there was no hope for alleviating their symptoms or returning to their former quality of life. In other words, there would be no escape from their unbearable suffering and no way to restore the moral status they lost while ill and impaired.

Structural factors again played into participants' hopelessness. China has a shortage of skilled mental health professionals and lacks robust community mental health services (Liu, 2011). Mental healthcare has become concentrated in urban psychiatric hospitals, of which there are only 557 nationwide, amounting to one psychiatric bed per 10,000 people in China (Liu, 2011). The lack of availability of mental health services is compounded by medical providers' low mental health literacy and stigmatizing attitudes toward mental illnesses (Wu et al., 2017; Stefanovics et al., 2016). These issues are particularly prominent in rural areas, where mental health awareness is lower and mental health services are more limited (Xu et al., 2018).

Many participants, both rural and urban, described traveling great distances, sometimes from neighboring provinces, to seek treatment for their depression. Most did not receive a referral to psychiatric care or an indication that they might suffer from a psychiatric illness until they had visited multiple different healthcare institutions. Even when participants were referred to psychiatric care, doctors seldom explained what depression was or addressed mental illness stigma, leading participants to initially believe psychiatric treatment was not an acceptable or viable option.

Somatic presentations of depression may also complicate help-seeking, leading to loss of hope for treatment. While somatic symptoms were often what drove participants to initially seek medical help, as discussed in Chapter 5, the fact that participants sought care from non-psychiatric specialists meant that doctors had difficulty diagnosing and finding an organic

explanation for their symptoms. Combined with low mental health literacy, somatic presentations of illness could have lead non-psychiatric medical professionals to believe there was no medical help available for participants' illness, adding to participants' hopelessness for an end to their suffering.

Hopelessness related to chronic illness

Even with treatment for depression, participants expressed hopelessness about a life lived with chronic illness.

Some participants believed depression to be an illness that would recur throughout their lives or an illness that required life-long medication. Others expected that depression would be cured entirely with treatment ("like the common cold") and were disappointed when it seemed that the illness might be chronic.

> *At the time when I had just gotten this illness, I felt like after treatment, I would recover very quickly. Also at the time, I was very confident that my illness could become better with treatment. Now the time that I've been on medication has gotten longer and longer, longer and longer, and the dosage hasn't decreased, so the pressure in my heart has gotten bigger and bigger.* [case 9-32-12-20, female, age 34]

Although medication may manage participants' symptoms, some participants talked about the stigma associated with taking long-term medication. For those participants, long-term medication implied that there was something fundamentally wrong with the person, signifying that their depression was not just a temporary obstacle but a personal condition.

> *According to our culture, depression is shameful. Long-term medication, as soon as you hear long-term medication, you know there's a problem.* [case 10-30-12-17, male, age 62]

Chronic illness was seen to limit life prospects, including ability to work and contribute to the family. This added to participants' feelings of uselessness, burdensomeness, and hopelessness.

> *My outlook may be a bit pessimistic. I just think, I may not be able to do much anymore. After all, with my illness, I may have to take a lifetime of medication, and I might not be able to do much anymore. Also, my body, I'm afraid if I return to work, I won't be able to handle it, and my illness will recur and get worse.* [case 17-18-12-10, female, age 35]

Some participants described how others' acceptance of them varied depending on how long the illness lasted.

> *I don't feel that [people who know about my illness have treated me worse]. Because this illness has not lasted very long. So people who know have been pretty sympathetic.* [case 9-39-11-20, female, age 67]

The participant implied that if her illness were to last longer, people would be less sympathetic and accepting of her illness. Similarly, other participants described how people's tolerance of their illness seemed based on an assumption that their illness was temporary and would be cured. One participant explained how everyone faces hardship at one point in their lives, and everyone must help each other out to some extent. In that sense, depression could be understood as a temporary hardship that requires others' help, which is expected from everyone at some point or another. However, participants also described how being chronically ill meant that one could never reciprocate others' help, making them "long-term useless."

> *[People] will say you are long-term useless, this is the fear that this kind of severe illness brings. And then in regards to family and work, within a certain time period, they will tolerate you, but past a point, past a certain point, there will be no going back to how things were.* [case 21-4-12-6, female, age 45]

In this way, participants' fears of chronic illness produced a particularly strong sense of hopelessness and moral threat. This also indicates that some ideas associated with chronic or recurrent depression in particular may overlap with stigma against disability and chronic illness to drive suicidal behavior.

Summary and look ahead

This chapter characterized participants' suicidal behavior and demonstrated how participants' motivations for suicidal behavior responded to sociopsychosomatic and moral experiences of depression. Participants' suicidal behavior was often motivated by suffering and impairment related to depression symptoms, participants' perceived inability to lead a moral life, structural factors that made mental healthcare difficult to afford and access (particularly for rural residents), and societal stigma and misinformation regarding disability, chronic illness, and mental illness. While participants often had moral reasons for engaging in suicidal behavior, the stigma against suicide stemmed from many of the same moral values surrounding reciprocity and obligation to the family. Although suicide is often thought of as irresponsible and irrational in Chinese society, most participants discussed how their suicidal behavior was motivated by reasonable and moral responses to their illness, to changes in their moral status, and to societal constraints like access to treatment.

The next chapter will draw together findings from Chapters 3 to 6 to examine overarching conclusions from participants' experiences of depression and suicidal behavior, as well as implications for clinical and public health practice and areas of further research.

CHAPTER 7: CONCLUSION

This chapter will draw together findings from the data chapters to elucidate some overarching conclusions, discuss the study's limitations, and identify possible areas of further study.

"Moral voice" of suicidal behavior and depression

Previous studies have identified depression and depression symptoms as risk factors for suicide in China, but few have investigated how and why depression relates to suicidal behavior. This data suggests the suffering and impairment of depression, combined with a lack of hope for recovery and a lack of others' understanding of their experiences, drove participants to suicidal behavior.

Moreover, the motivations for participants' suicidal behavior were often moral in nature. Much of participants' suicidal behavior stemmed from their perceived inability to lead a moral life, due to the limitations of their illness and illness-related stigma. Participants often wanted to die because they felt they were "useless" (unable to fulfill family obligations) and a "burden" (requiring more from their family than they were able to reciprocate). While these moral considerations derived from long-standing cultural values surrounding reciprocity, they were also shaped and constrained by structural factors that made mental healthcare difficult to afford and access, particulary for rural residents, and societal stigma and misinformation regarding disability, chronic illness, and mental illness.

As such, suicidal behavior should not be thought of as merely a "symptom" of depression, which implies that it is an amoral and socially detached form of pathology. Rather, participants in this study described how their suicidal behavior *responded* to aspects of their experiences of depression, which were influenced as much by their symptoms as by how they

and others interpreted the meaning of their symptoms. This study does not rule out the possibility that biological causes of depression (like chemical imbalances in the brain) might somehow produce suicidal ideation, or that depression symptoms might exaggerate perceptions of hopelessness, burdensomeness, etc. However, treating suicidal behavior solely as a symptom of depression positions it as irrational, obscures how different social/cultural/structural factors related to experiences of depression influence suicidal behavior, and invalidates the distress that suicidal behavior communicates.

Lee (2011) argued that attributing suicide to depression turns suicide from a social problem into a disease, thereby "muffling the moral voice of the suicidal individual" in China. Wu (2011) similarly asserted that, among the rural Chinese communities he studied, depression was a side effect of moral conflicts within the family that drove suicidal behavior, rather than a direct cause of suicide. Many other studies have attempted to understand whether depression is responsible for suicidal behavior by quantifying how many people who died by suicide were likely depressed and measuring the predictive value of depression as a risk factor for suicide.

The underlying stake in debates about whether depression causes suicide is the concern that suicide will become medicalized—reduced to a biological issue of a "chemical imbalance in the brain" rather than something that has social origins and a "moral voice" (Lee, 2011). However, the unchallenged implication is that depression has no moral voice and is not a social or moral issue. Such an implication plays into the stigmatizing idea that mentally ill people are incapable of rational thought and moral judgment and thus their suicide cannot be considered a moral act (Wu, 2011). As participants in this study have demonstrated, depression has a moral valence that has not often been studied, and suicidal behavior often directly responds to this moral valence. Moreover, experiences of depression symptoms were often intimately tied with

experiences of societal and interpersonal distress, and this sociopsychosomatic suffering also contributed directly to participants' suicidal behavior. As suicide increasingly becomes attributed to depression in Chinese public discourse, challenging the medicalization of suicide also requires challenging the medicalization of depression, rather than diminishing the role that depression may play in suicide or overlooking the experiences of suicidal behavior among people with depression.

Social and moral experiences of depression

Many studies have challenged the medicalization of depression in China by showing how neurasthenia, commonly thought of as the antecedent to depression in China, had a culturally-specific social course and meaning, which depression as a "Western" diagnosis did not necessarily capture (Ware and Kleinman, 1992; Lee, 1999). This study updates those understandings by examining the social course and moral experience of depression among Chinese inpatients in the present day.

Participants believed an interplay of social disharmony and individual inability to cope explained the onset of their depression. Interpersonal conflict played a central role in participants' distress, which was felt emotionally and bodily. In addition to this interpersonal distress, they blamed their own tendency to "think too much" or take things too hard, which referred to an inability to cope with, resolve, or let go of the disharmony in their lives. In participants' explanatory models, this dysfunctional processing of social stressors created a "vicious cycle" of somatic and psychological symptoms that mutually reinforced each other. Further, their social, psychological, and somatic distress were so intertwined that distinctions made between psychological and somatic symptoms were often ambiguous and ambivalent. Just as participants felt like they had no social or individual means of processing interpersonal

disharmony and releasing negative emotions, they also felt physically blocked, swollen, and suffocated, creating pain, dizziness, and sleeplessness. Similar to participants' explanatory models, their ideas for recovery involved an interplay of interpersonal support, medical help, and self-regulation in order to "open up" and "walk out" from under their illness.

While participants' social relationships shaped their illness, their illness—and the meaning attached to their illness—also altered their social roles. The meaning of depression for participants was often moral in nature. Depression impacted their perceived ability to be moral persons and live moral lives by threatening their role within the family. The functional and work impairment that participants faced limited their ability to fulfill moral obligations as "good fathers," "good mothers," "good daughters," etc., which created guilt and shame at being "useless." The high cost of mental healthcare, particularly for rural residents, added to participants' sense of guilt at burdening their families with their illness. Participants' moral status was also threatened by their perceived loss of self-control, which included the idea that participants could not manage their own problems and the fear that they would become "crazy," or lose rational thought and moral judgment.

These threats to moral status hold clinical relevance in that they reveal what was most at stake for participants in their illness and treatment—to preserve their social roles through retaining their "usefulness," autonomy (self-management), and moral agency. These moral priorities might at times be at odds with medical authority, which in some ways demands that the patient cede autonomy and agency to the medical professional. In addition, treatment for depression can interfere with functional status—many participants complained that the side effects of medication impacted their ability to work, which has been shown to lead to medication non-adherence in other studies in China (Chai et al., 2021). Further, participants' moral priorities

can also be at odds with the sick role that the family expects the patient to play—in China, many families might believe that people suffering mental illness ought to avoid responsibilities to prevent straining themselves and exacerbating their illness (Yang et al., 2009). While this may provide patients with needed rest, it could also add to feelings of "uselessness" and remove patients' autonomy and agency. Instead, clinical treatment and anti-stigma intervention programs in China could prioritize preserving or regaining patients' role within the family in accordance with person-centered treatment goals (Tang and Wu, 2012).

Stigma and moral meanings of depression

This study also demonstrates the importance of combining increased public awareness of depression with greater understanding of depression stigma and increased efforts to combat it. This study expands upon studies that have shown high levels of perceived and personal stigma toward people with depression in China (Yang et al., 2020) by exploring how this stigma relates to core moral concerns regarding reciprocity and mental control. This study further showed how stigma impacted participants' symptom presentation and engagement with clinical institutions.

Increased access to mental healthcare in China should be accompanied by greater investment in anti-stigma interventions among communities and healthcare professionals. This study highlighted how aspects of mental health treatment itself might have stigmatizing or moral implications, such as long-term medication signifying something fundamentally wrong with the individual, and further studies could investigate how to manage these stigmatizing conceptions in clinical and community settings. Moreover, since participants most often sought support within the family and were most hurt by family members' stigmatizing views or lack of understanding of depression, anti-stigma interventions and mental health education efforts could prioritize teaching ways of offering family support.

This study also suggests that not all stigma surrounding depression in China is unique to depression itself—rather, participants described how the prospect of being "disabled" or chronically ill contributed to their moral distress and suicidal behavior. Participants' guilt and shame about being "useless" overlap with stigma around disability in China (Kohrman, 2005), such that efforts to reduce stigma around depression in China should also address and be mindful of disability stigma. Further, participants' particular anxieties about long-term or chronic illness highlight an aspect of depression that has not often been explored in research on depression stigma in China. Future studies could examine the particular experiences of chronically depressed people in China in more depth and investigate how stigma against chronic illness may impact aspects of mental healthcare like medication adherence. While many studies have examined disability stigma (Kohrman, 2005) and chronic illness stigma (Kleinman et al., 1995) in China, as well as disability and physical illness' role in suicidal behavior (Jia et al., 2014, Li et al., 2012; Wei et al., 2018; Zhang et al., 2004), few have examined them in relation to depression in China. The moral threats that participants described around being disabled or chronically ill may warrant greater dialogue among researchers of disability, chronic illness, and depression in China.

Participants also described the moral threat of belonging to a broad stigmatizing "mentally ill" (*shenjingbing)* category that may include depression. While *shenjingbing* often refers to behaviors related to psychosis, and studies have shown that Chinese people have less stigmatizing views toward depression than they do toward schizophrenia (Lee et al., 2016), the stigma that participants feared around being "mentally ill" in general suggests that stigma against schizophrenia and other mental illnesses might also impact stigma against depression. As such, anti-stigma efforts for depression should go hand-in-hand with anti-stigma efforts for

schizophrenia and other mental illnesses, rather than attempting to distance depression from more stigmatized mental illnesses.

Significance of somatic symptoms of depression

Somatic symptoms of depression in China have been an area of particular focus, in part because they suggest a cultural difference in experiences or presentations of depression between Chinese and "Western" societies. While this study did not compare among different cultures, it noted a tendency among participants to emphasize somatic symptoms and somatic experiences, even though participants described nuanced and interwoven relationships, as well as significant overlap, between their psychological and somatic experiences. Many participants' somatic emphases seemed to stem from not only an explanatory model of depression that posits that psychological symptoms can be self-regulated, but also a normative idea that psychological symptoms can be self-regulated. This normative idea goes back to moral implications surrounding self-control and affected how participants presented their illness to others, including medical professionals.

However, somatic emphasis was not only a matter of presentation, but also reflected participants' felt experiences of depression symptoms. While cultural or societal factors may have influenced how participants presented or focused attention on their symptoms, this does not mean that participants did not genuinely experience somatic symptoms to be most salient. "Cultural scripts" around how distress is felt and expressed may influence the experience of distress itself (Ryder and Chentsova-Dutton, 2012). Perhaps for that reason, in combination with mental illness stigma, participants described feeling invalidated when told the nature of their somatic symptoms was psychological or non-existent.

This study suggests that somatic symptoms matter, both for how participants understand and experience their illness and for how they approach treatment. Because many participants were driven to seek help by somatic symptoms, and medical providers did not refer them to mental healthcare or did not address mental health stigma in their referrals, these participants often experienced more debilitating symptoms, increased hopelessness, and increased suicidal behavior as a result of ineffective help-seeking. Participants' often convoluted pathways to mental healthcare align with another study's findings that over 75% of patients with mental disorders at an urban Chinese hospital took indirect pathways to psychiatric care, that they consulted an average of 3.4 caregivers, and that less than 10% of those who first visited a non-psychiatric hospital received a timely referral or appropriate psychiatric treatment (Zhang et al., 2013).

The findings of this study highlight a need to increase awareness of somatic aspects of depression among medical providers and the Chinese public, as well as to invest more in training for medical providers on recognizing depression and addressing mental health stigma in referrals. Participants' understanding of depression indicated that while awareness of depression may be growing, this awareness (when not accompanied by lived experience) concerns a relatively narrow conception of depression as an illness defined by its psychological symptoms and association with suicide.

Further, the study findings underscore a need for integrating physical and mental health services in community and primary care settings in China to increase access to and acceptance of mental healthcare. While China has initiated efforts to integrate mental healthcare with the general healthcare system via the 686 Programme in 2004 and the National Mental Health Working Plan in 2015, these efforts have focused on "serious mental illness" as indicated by

psychosis and violent or socially disruptive behaviors (Liu et al., 2011; Liang, Mays, and Hwang, 2018). Moreover, these efforts are also hampered by limited funding, limited number of mental health professionals, limited epidemiologic data on mental illnesses, and rampant mental illness stigma, such that China still has a long way to go to integrate mental health services (Liang, Mays, and Hwang, 2018). This study adds to evidence of an urgent need for this integration and contributes to understanding of the social and moral stake behind emphasizing somatic versus psychological symptoms.

Finally, the role that somatic symptoms play in suicidal behavior among Chinese people with depression is an under-researched topic. While studies have examined how insomnia (Li et al., 2010) and chronic pain (Liu et al., 2021) increase suicide risk among Chinese populations, the contribution of somatic suffering to suicidal behavior (and the significance of this suffering being somatic) has rarely been discussed in relation to depression in China. This could pose an area for further research.

Structural factors in moral experience

While studies on moral experiences of illness have tended to focus on cultural factors that affect how people understand the moral meaning of illness (Yang and Kleinman, 2008; Yang et al., 2010), structural factors also play a role in dynamically shaping moral experience. This study discussed some structural factors like unaffordable mental healthcare, inaccessible mental health services, separation of mental and physical healthcare, and rural-urban inequality that interacted with cultural values like reciprocity to affect participants' moral experiences of depression and suicidality. Other studies have investigated how social determinants of health (socioeconomic status, social cohesion, and negative life events) were associated with varied levels of depression among a sample of rural Chinese (Liang et al., 2012), as well as how poverty and depressive

symptoms mutually reinforced each other over time in China (Jin, Zhu, and He, 2020). It would be interesting for further research to integrate theory around social and structural determinants of health with theory on moral experience to elucidate the complex interplay of cultural, moral, social, and structural factors that shape experiences and meanings of depression and suicidality among Chinese people today. Such research could identify how mental healthcare in China can be expanded and improved to increase needed access to treatment while preserving the moral voice and social significance of depression and suicidal behavior in China.

Limitations

Since this research is qualitative, it is only intended to reflect the perspectives and experiences of the specific group of people included in the study. Thus, the findings should not be generalized beyond the study population, but the findings can further understanding of certain phenomena and highlight areas of further research or topics that have been missing from larger discourse.

Particular aspects of the study setting and population may influence the transferability of the findings. Most importantly, this study involved an inpatient population of a psychiatric hospital. Given that over 90% of Chinese citizens with a mental disorder fail to get any kind of professional help, an inpatient psychiatric population already represents a very small subset of people with depression (Phillips et al., 2009). An inpatient population might have more severe or debilitating symptoms (warranting inpatient care over outpatient care) and more chronic or recurrent illness (producing greater familiarity with mental health services). The participants in this study may have had more prior awareness of mental health than others—a few participants said they knew to come to Nanjing Brain Hospital because they had a relative or neighbor who had been depressed before. Further, because of participants' exposure to psychiatric care, they

might have adopted more biomedical explanations for their illness and endorse more psychological symptoms. However, because somatic symptoms were often what drove participants to seek medical help in the first place, a help-seeking population might also have more somatic symptoms. A help-seeking population is also more likely to believe depression is an illness that can be treated with medical intervention, as opposed to a personal, social, or spiritual problem that can be resolved individually or with the help of friends, family, or non-medical professionals.

In addition, this study was conducted in an urban hospital. Although 36% of participants resided in rural areas and 55% grew up in rural areas, certain characteristics are likely to distinguish this population from other rural Chinese with depression. Some rural participants said they knew of Nanjing Brain Hospital because they had a child or relative who worked in Nanjing. This meant their families might have had more means and been more upwardly mobile than other rural families. However, it also may have indicated greater distress from experiencing family separation. Indeed, previous studies have shown how being "left behind" by children moving to urban areas can be a risk factor for depression and suicide among elderly rural Chinese (Zhou et al., 2018). Overall, although Nanjing Brain Hospital may have been one of the only options for rural residents to receive mental healthcare given the lack of rural mental health services (Xu et al., 2018), the difficulty of accessing mental healthcare meant that rural participants in this study likely represented a very small minority of rural residents with depression who were willing and able to travel to seek mental healthcare.

The clinical setting may also have biased participants' responses. While I tried to minimize this bias by emphasizing that I was not involved in participants' treatment and asking participants how they talk about their illness with friends or family, participants may still have

felt inclined to talk more about things they found relevant to a clinical setting, like somatic symptoms (Cheung and Lau, 1982; Simon et al., 1999).

It should also be noted that this study examined suicidal behavior but not completed suicides, and that it only looked at suicidal behavior among people with depression. While suicidal behavior has been shown to be a risk factor for completed suicide, with suicide attempt being a particularly strong predictor (Nordstrom et al., 1995; Brown et al., 2000), suicidal behavior and completed suicide may have different characteristics and drivers. Moreover, 30% or more of suicides in China are done by people who likely would not have qualified for a depression diagnosis (Phillips et al., 2002; Lee, 2011; Wu, 2011). As such, this study should not be taken as a complete picture of suicide in China, but rather a window into a specific set of experiences of suicidal behavior among a group of inpatients with depression.

There were many interesting aspects of the data that might warrant further study but that did not tie into larger themes in the data. For example, gender and age differences in experiences of depression and suicidal behavior were not investigated in much depth. It is notable that only 27% of this study's participants were male, which roughly reflected the proportion of male inpatients as well. Given the difference in psychiatric help-seeking between men and women in China (Chen et al., 2020), it is likely that there are also gender-related differences in experiences of depression that warrant further study. Further, many participants' experiences of depression and suicidality were specific to their age group or stage in life as students, young adults, young parents, middle-aged adults, retirees, etc., so further studies could investigate experiences of a particular age group in greater depth.

Conclusion

This thesis furthers understanding of the complex interrelationships between social, moral, psychological, and somatic experiences of depression among Chinese inpatients, how these experiences are informed by cultural values and structural barriers to care, and how these experiences influence suicidal behavior. While the study offers one window into a specific set of experiences, it also presents implications for targets for depression treatment, anti-stigma intervention, and suicidal behavior prevention; highlights how structural issues with mental health service delivery interact with moral values in China; and informs future research on the intersection of depression, disability, and suicidal behavior.

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(N.d.).

APPENDIX

Interview topic guide

INTERVIEW TOPIC GUIDE
(some questions adapted from Cultural Formulation Interview in DSM-V)

1. What brings you to the hospital?
    a. Probe: People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would you describe your problem?
    b. What does it feel like when you're ill/unwell?
2. Sometimes people have different ways of describing their problem to their family, friends, or others in their community. How would you describe your problem to them?
3. What troubles you most about your problem?
4. Why do you think this is happening to you? What do you think are the causes of your [PROBLEM]?
5. What do others in your family, your friends, or others in your community think is causing your [PROBLEM]?
6. Sometimes people have various ways of dealing with problems like [PROBLEM]. What have you done on your own to cope with your [PROBLEM]?
7. Often, people look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing have you sought for your [PROBLEM]?
    a. Probe: What types of help or treatment were most useful? Not useful?
8. Has anything prevented you from getting the help you need?
9. What kinds of help do you think would be most useful to you at this time for your [PROBLEM]?
10. Are there other kinds of help that your family, friends, or other people have suggested would be helpful for you now?
11. Have you received or are you receiving the help you need?
12. Have you ever thought about wanting to die or not wanting to live anymore?
13. Have you ever thought about ending your life?
    a. Why do you think you had/have these thoughts?
    b. When/how often did you have these thoughts?
    c. Have you ever thought of a method or a plan for ending your life?
    d. Have you ever tried to end your life?
    e. Have you told other people about these thoughts? How did you talk about it? How did they react?

Coding structure

Code Level 1	Code Level 2	Code Level 3
symptom presentation	chief complaints	head complaints
		brain/cognitive complaints
		breathing complaints
		eating complaints
		chest/heart complaints
		emotional complaints
		stomach/abdominal complaints
		limb complaints
		whole-body/pre-verbal complaints
		sleep complaints
		fatigue
		avolition
		suicidal behavior
	presentation to others (friends and family)	depression
		nonspecific psychiatric illness
		psychological problems
		physical symptoms
		nonspecific illness
		hide from others
	disability experiences	employment disability
		movement disability
		functional disability
		relational disability
suicidal behavior	type of suicidal behavior	wanting to die by suicide
		thinking of method of suicide
		planning for suicide
		suicide attempt
	motivation for suicidal behavior	unbearable suffering
		feeling useless
		stressful events
		feeling like a burden
		loneliness/isolation
		hopelessness
		thinking too much

	presentation of suicidal behavior to others	hide from others
		confide in family
		confide in friends
		confide in medical professionals
illness beliefs	causal factors (what patient personally believes to have caused or	personality
		interpersonal conflict
		societal conditions
	contributed to their own illness)	physical conditions
	nature of depression (medical disease category)	associated with suicide
		associated with cognitive problems
		associated with emotional problems
		associated with personality
		associated with stressful events
		not a real illness
	sources of information (regarding depression)	media
		medical professionals
		personal network
	stigma (regarding their illness or depression)	shame
		lack of shame
		mis/non-understanding
help-seeking	reason for seeking care (if stated explicitly)	head complaints
		brain/cognitive complaints
		breathing complaints
		eating complaints
		chest/heart complaints
		emotional complaints
		stomach/abdominal complaints
		limb complaints
		whole-body/pre-verbal complaints
		sleep complaints
		fatigue
		avolition
		suicidal behavior

	pathway to care	brought by family
		sought care in other specialties
		referred by family
		referred by friend or acquaintance
		referred by medical professional
		direct visit (to psychiatric care)
	barriers to care	illness beliefs
		general reluctance to seek help
		access to care
	previous care experience	full recovery through psychiatric care
		incomplete recovery through psychiatric care
		no recovery through psychiatric care
		full recovery through self care
		incomplete recovery through self care
		no recovery through self care
		full recovery through medical care
		incomplete recovery through medical care
		no recovery through medical care
	hope for recovery	no hope
		hope for medical treatment (modern medicine)
		hope for medical treatment (traditional medicine)
		hope for non-medical treatment

Transcript excerpts

Participant 9-17-12-16, female, urban Nanjing residence and birthplace, age 32

What brings you to the hospital?
I started working….and then, after I started working, I wanted a lighter position so I could take care of my baby (crying) and then I got it (crying) and after I got it, I always wanted to do well at it. I just find that when I'm chatting with coworkers, in college too, I tend to care about what other people think…(sigh)….and when I got home, I started to, not be able to sleep a little bit. Actually being home these past couple days, I've been able to sleep pretty well. Because my parents are by my side caring for me. They've felt that I haven't been self-reliant enough since childhood, that my self-reliance has been rather poor, so they'll use more of a reprimanding educational style with me. Now that I'm raising a child myself, I worry that this type of family atmosphere will affect my baby. And then, with regard to work, I want myself to become happier, and then I find that, the more I want to be happy, the more I look for happiness, the harder it is. My father is in his 70s now, my mother is in her 60s, and I actually feel very guilty that they're following me around and taking care of me. So I want to tell Dr.--- that I want to slowly leave the hospital. In any case my coworkers already know I have this illness, I feel like I can begin to calmly accept it. I've always wanted to be strong, but after all I have this illness. But I still need to return to my job. I feel like if I'm always at home, following after my parents—they've been poor since childhood (crying). That's why I always wanted to be a useful person when I grew up (crying) ….because I want to go to work, I want to be a good role model for my daughter, I think girls have to grow up to be self-reliant. Self-reliant means having a job, not relying on a man to live. ….Self-reliant means being able to be happy on one's own (crying). Also, being in this hospital, taking this medication—I think most women are all living happily, whereas I've always been so depressed with low self-esteem….I feel like I'm not such a courageous person and I can't let go either. I've already been ill and hospitalized three times now, I don't want to stay in the hospital anymore (crying) (sighs) (pauses)

What does it feel like when you're ill?
When I'm ill my head hurts, actually, when I'm breastfeeding also, my chest will hurt, it'll hurt on both sides. My family doctor said I have a nodule in my lungs, maybe because of the long-term depression, and I'm coughing a bit. Before, when I was working, I would listen to everyone, and I would make my own life so depressing.
[…]

How do you go about searching for happiness?
I…the other day I was telling the person in this bed and this bed—because this may have been their first time being hospitalized, and I hoped that they wouldn't be like me—I told them how I came to be hospitalized a few times, and it seems that the reasons were all related to romantic relationships. Mostly that my own spirit is not independent enough, and then I look for happiness. I asked several women whom I consider to be mentally independent how I should be, including the attending doctor at the hospital. The doctors replied, 'Be yourself, don't resist it.' Every time I get ill I'll buy a few books, I think maybe it's that I don't read enough. I listened to some parenting things, and then when I got home, my husband said I listened to too much, successful people's success wouldn't actually be written out, what's been written out is all fake, if someone was really successful they'd be happy, so you should just lie in bed and watch Tik Toks and take some medication.
[…]

Do you feel like your previous treatment has been helpful?
….The last few times I was hospitalized, I actually don't really remember, I just remember that there was a lot of medication, my friends came to see me, they showed me some articles telling me how I should be. At the time I was 19 years old, now I'm 32 years old. This time I didn't want to let my parents come see me, because they still have to help me take care of the baby. I want to know how intense my exercise should be, and if I can just slowly go to work next week, or maybe after my next session of psychological counseling. I want to learn how to get along well with others, how to talk to people at work, and then, I want to take less medication. I don't want to rely on medication, I want to rely on my own willpower.
[…]

Why do you feel that way about medication?
(pause) Because I feel like…healthy people, people with a positive attitude, they all wouldn't be like this mentally. Maybe because of stress, it would make them have a bad heart, or it would make them have a bad stomach, or it would make a marathon runner's leg cramp up, but in those cases they would already have gotten their life's fulfillment. But depression is just self-pity, like the type of person who won't work hard.

Do you feel like depression is something to be ashamed of?
A bit yes

Why do you think that?
(pause) Because I feel like strong people…because I feel like I'm among a new wave of women, or I want to be that type of person, and that type of person wouldn't get depression.
[…]

Have you felt lonely because of your illness?
….I feel like why is it that none of the girls out there will think too much about nonsense. I feel like normal girls out there hang out with each other, even if they're the trash-talking smoking type, their skin is all good, they don't need to take antidepressants, I feel like that's what being good is. Like me taking this medication, making my parents worry, I feel really guilty inside, you know? They said the two times I didn't get better before were all because I fought to leave the hospital without the doctor's agreement.

Why did you want to leave the hospital?
At that time, I was anxious to graduate from college and lessen some of the burdens in my family.
[….]

Do you feel like you can control the important things in your life?
(pause) I've already gotten married and had a baby, so I've already completed the big things in life. The next important thing would be my child's education. I just feel like a mother should be a good role model. I'm always asking what a good mother is. They all say it's someone who can solve any problem they encounter on their own. So my illness is something I will have to get over.

Participant 14-9-12-3, female, rural residence and birthplace, age 61

Why have you come to the hospital?
Because I can't sleep, I haven't been able to sleep for a long time, I can't sleep day and night. I can't close my eyes for even a moment, not even a bit. It's been like this for two years. I never sleep all day long, not in the day, and not in the night. At night I get into bed and I have my eyes open until daylight. In the day I just wait until night, and still can't fall asleep. And then when I wake up I just leave the house and pace back and forth, and my heart burns very uncomfortably. When I first became ill, it wasn't like this. And then gradually I got heartburn, and my farts became like a hot wind, like burning. And then it was always like this, for several months. On May 29 I checked into Zhongda Hospital, stayed there for 10 or so days, and went home after that. I took medication for three months, and it was pretty good. After that some small things happened at home. My husband has a bad temper. At night after he's eaten dinner and has nothing to do, he likes to drink. My daughter had her second child, the older is 15 and the younger is 3. He was drinking at night and he got wine glasses, one big and one small. He gave the small one to the younger child and toasted him. When the older child saw the younger one holding a wine glass, he put the glass on the floor and went to the kitchen to get slightly bigger glasses, and gave one to each of them. The older one was teasing the younger, just for fun, and took the younger one's glass away, and the younger one starting crying and making a fuss. The old man got angry, and all of a sudden he smashed the glass. I didn't say a word, when my daughter got home she got angry. She didn't eat, just took her kids away crying. From that moment on it was like I started getting ill, I couldn't sleep day in and day out. I can't bring him up, if I bring him up, I start getting angry. The entire time I've been with him, even though we're married, we've basically fought our whole lives. He's rather strong-willed, he thinks that he earns more, so when he's talking or doing anything, it's like he's giving orders. I don't want to mind him, so I just stuff it all in my heart. I don't want to tell my daughter either, and I don't want to tell other people, I can only let myself slowly digest it in my stomach. It takes many days to digest, and sometimes when I remember it it becomes stuck in my chest. This is how it's slowly turned into this illness. Whenever I bring him up, my chest gets blocked. When I see him talk, the anger starts in my heels, and I hate him so much. Why do I hate him? It's impossible for me to have gotten this kind of illness on my own. I used to not talk, I never let out a squeak at anything, I put everything in my heart. I never let him do anything, I took very good care of him. My daughter got married at 24, at home I never let her wash a single pair of pants or pair of underwear. It's all me doing everything, I never wanted her to do anything, so she's been blessed her whole life. My husband's work is very comfortable, every day he just takes a cup of tea with him to work, and talks very aggressively when he gets back. He's like a lord, he doesn't do anything, and has been blessed all his life. I get angry whenever I think of him. I think my illness is because of him. I don't know what's been happening over the past few months, but whenever I bring him up, I hate him so much that I immediately feel like falling over, that kind of feeling. […]

My goodness, this time that I've been ill, I feel like I'm useless, I feel like I'm no use at all.

Why do you feel this way?
I feel like I'm like a disabled person, unable to do anything. I can't sleep. When I'm at my daughter's house, my daughter's house is big, and I get up and I feel like I have to do my work even if I have to grit my teeth. I sweep and mop, it's like this every day. I get up in the morning, secretly wash my underwear in the bathroom, and wait for them to get up before taking them to dry. When they get up, the little things are basically done. I live in her house and I can't add to her burden. She needs to help take me to

the hospital, so I help her with some housework. I need to help her with the housework even if I have to grit my teeth, I'm just this kind of person.

Can you still do the housework when you're ill?
I do it, I keep doing it, I'll do it until I can't get up. My daughter won't let me do it. She said there's a massage chair at home for me to use. I can't use it. I'm thin now, and the massage hurts everywhere. It hurts just to the touch. My daughter doesn't want me to do it, but I do it anyway.
[…]

Have you told others that you have depression?
No. I also tell my daughter not to tell others because other people will look down on it.

Why do others look down on it?
People will say, she is insane, she is sick. I didn't tell anyone I was hospitalized, no one knows. I stayed at the hospital twice and no one knows.

Has anyone ever treated you poorly because of your depression?
No. Before, if I had nothing to do, I danced. I haven't danced for a few months now. Sometimes when the old man comes to bring me food, he says I ran into so and so today. I asked him to tell people that I am at my daughter's house, since I haven't been going home. Just say that my daughter is too busy taking care of two children by herself. Others will ask me why I don't go dancing, I haven't gone dancing in months.
[…]

What kind of treatment do you think would be most helpful?
I don't know what other treatments are available. Anyway, I've been sleeping okay the past couple days, I've only gotten out of bed once in the night.

Your sleep has been getting better?
Yes it has.

At what point do you think you won't be ill anymore?
If they can make it so I can sleep well, I can recover naturally, my body can recover naturally. When you sleep well, you can take care of it naturally.