

COMMENTARY

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DOES CRISIS FOSTER OPPORTUNITY? A COMMENTARY ON "DIAGNOSIS POSTPONED: SHENJING SHUAIKUO AND THE TRANSFORMATION OF PSYCHIATRY IN POST-MAO CHINA," BY SING LEE

In "Diagnosis Postponed: Shenjing Shuairuo and the Transformation of Psychiatry in Post-Mao China," Dr. Sing Lee presents a broad overview of the current status and trends in psychiatry as practiced in China, using the decline of Shenjing Shuairuo (SJSR) (neurasthenia) and the emergence of depression to highlight the power of social, economic and political forces in shaping the prevailing mode and practices of clinicians. Dr. Lee's descriptions and syntheses are cogent, succinct and persuasive. The depth of his insight and perspectives are indispensable for clinical researchers and social scientists interested in the mental health care of one-fifth of the human race. Perspectives presented in this paper should also prove valuable for policy makers and leaders of the field who are facing the challenges of reshaping the mental health and health care systems for the populace of this vast country. Many issues covered or touched upon by this paper are important and fascinating. However, because of limitations in space and time, my commentary will focus on two major themes: (1) the longstanding controversy regarding the relationship between SJSR and depression, and (2) the tension between the power of the "system" and the rational care of patients. This commentary will end with a cautionary note of hope, pointing out forces that may converge in the near future to effectively deal with problems that are discussed in Dr. Lee's paper as well as in the accompanying commentaries.

IS SJSR "MASKED DEPRESSION," OR IS DEPRESSION A "PSYCHOLOGIZED" FORM OF SJSR?

It is commonly assumed that most "non-psychotic syndromes" (so-called "minor" psychiatric disorders) represent discrete clinical entities (Robins



and Barrett 1989). The DSMs have worked hard at clarifying the clinical features that may be at the core of these syndromes, hoping to identify the natural lines of demarcation among them. However, after several decades of concerted effort, the results are extremely limited (Kendler and Gardner 1998). As currently defined, most of these syndromes overlap extensively with one another, with "co-morbidity" rates easily approaching 50–75% (Kessler et al. 1998; Tyer 1989). Furthermore, recent data indicate that so-called "sub-syndromal" cases, although not diagnosable according to official criteria, are often significantly distressed and dysfunctional (Judd et al. 1998). Although such ambiguities and uncertainties regarding the boundaries of psychiatric syndromes as currently defined do not necessarily indicate that boundaries do not exist, they do raise serious questions regarding the wisdom of the "categorical" approach, which serves as the guiding principle for our contemporary nosological paradigm.

In the vast majority of the psychiatric patients, symptoms representative of these supposedly discrete syndromes (e.g., depression, anxiety, fatigue and other somatic symptoms) typically go hand in hand in their frequency and severity. Thus, it could be argued that the artificial partitioning of such patients into different diagnoses according to the relative strength of any particular "dimension" of the totality of their distress at any given point of time is largely arbitrary, and may even be counter-productive. If this is so, then it may actually have been a mistake to discard "older" concepts such as neurasthenia (SJSR in Chinese), whose clinical features encompass both somatic and psychological (often with depression and anxiety coexisting side by side) manifestations. As much as it may make sense to speculate that some SJSR and related "somatoform" patients are "somatizers" (who focus more of their attention on somatic rather than psychological symptoms), it could also be argued that the reverse may be equally true: many other patients may have similar clinical pictures but may qualify for the diagnosis of one of the DSM mood or anxiety disorders because of their "psychologizing" tendencies (Romanyshyn 1982).

Since depressed patients often respond to "antidepressants," it often has been assumed that those with relatively more prominent somatic and less distinctive psychological symptoms must have suppressed or repressed their depressive mood if they also respond to the same class of medications (Lesse 1983; Barrett et al. 1988). However, since antidepressants have also been proven effective in the treatment of a large number of other conditions, their specificity vis-a-vis depression is by no means clear (Potter, Manji and Rudorfer 1995). They certainly are not "happy pills," but exert their effects by somehow "energizing" or resetting functional aspects of brain circuitry that regulate the autonomic, endocrinological and

immunological activities on the one hand, and the experience and expression of mood on the other. Congruent with this view, a number of studies have demonstrated that significant somatic/vegetative symptoms are at least as good as psychological symptoms in predicting "antidepressant" responses (Burns et al. 1995; Linden et al. 1994). For these reasons, the term "antidepressant" might actually be viewed as a "misnomer."

Given the continuing ambiguity and uncertainty of the boundaries of various "neurotic" conditions as presently defined, debates on the utility of the current diagnostic systems are rampant and ongoing, both for research (Smoller and Tsuang 1998) and clinical purposes (Frank et al. 1998). Compounded by the huge problem of "categorical fallacy" in transplanting a classification system from one culture to another (Kleinman 1988), the precipitous replacement of SJSR by depression in psychiatric practices in China in recent years is remarkable as well as troublesome. This is especially so since, in all likelihood, the label of depression would not make sense to the patients, or would still be regarded as socially stigmatizing (albeit possibly no longer politically endangering or "suicidal"). The swiftness of the change is truly astounding, and can not be adequately understood without taking into account the sweeping and massive changes in the social, economic and political landscape that are currently taking place throughout China.

PSYCHIATRIC PRACTICE IN AN EVER CHANGING WORLD

Since clinical care never takes place in a vacuum (nor should it), physicians knowingly or unknowingly negotiate with various societal forces in striving to bring the best care for their patients. In times with relative stability, this may be comparatively less challenging, since rules and expectations concerning therapeutic conduct are relatively more clearly defined. In contrast, during periods of transition, shifting standards and conflicting demands may render the healing profession exceedingly tension-prone and anxiety-laden. Such transition periods may also create the opportunity for the unscrupulous or the naive to collude with economic or political interests, and to rationalize decisions that may be substantially deviant from previously held ethical ideals. In the U.S., the current frenzy over the managed care "reform" produces ample examples, demonstrating how easily clinical decisions could be sabotaged or biased by market or profit oriented concerns (Goldman et al. 1998). Similarly, the current debate on the issue of parity (between the coverage for mental health and other health care) also has little to do with the cost-effectiveness of psychiatric care, as well as the welfare of individual patients and the

communities, but is largely driven by political and social (stigma related) factors (Michels 1998). A generation back, a payment and incentive system favoring inpatient psychiatric care fostered an outburst of hospital construction and the excessive and inappropriate use of such facilities (Mechanic, McAlpine and Olfson 1998). In some cases this trend led to the packaging of inpatient psychiatric care as "vacations," and the abuse of civil rights of patients.

However, these American examples may be dwarfed by the sweeping changes that are taking place in the Chinese mental health systems in recent years. Subjected to the relentless onslaught of commercial forces, the organized marketing skills of super-national pharmaceutical companies and other commercially oriented interests (including the "selling" of the DSMs), and an avalanche of novel ideas and practices, commonly presented or perceived as scientifically based, it is hardly surprising that clinicians' outlook, orientation and practices would change. The way health care is organized would also be transformed, for better or for worse.

Dr. Lee's account focuses primarily on the effect of these shifts on the diagnostic practices of clinicians. However, his material leaves little doubt that the impact of these changes is not just limited to issues related to nosology, but is far more outreaching and pervasive. Such influences in two other important areas, namely programs for aftercare and rehabilitation, and psychiatric research, will be briefly discussed in the following.

As described by a number of authors, the long-term care of the severely mentally ill had been one of the strengths of the psychiatric services system up until the early 1980s (Lin and Eisenberg 1985; Livingston and Lowinger 1983). Prior to the privatization of the nation's economy and the "Open Door Policy," Chinese in general enjoyed a remarkably high level of social stability, despite the upheavals of the Cultural Revolution as well as its precursors (Liu 1984). The almost unprecedented level of social control and restriction in social mobility might have been suffocating for the general populace, particularly for those who were adventuresome and restless. However, for those afflicted with severe mental illnesses, such as schizophrenia, the stability and rigidity of the social structure could actually be a blessing, especially for those living in urban areas and belonging to a work unit (e.g., factories, schools, the party, governmental agencies). After acute treatment, patients were typically discharged to the family, the work unit and the neighborhood. Job security and financial support were guaranteed. In such a milieu, it was relatively less difficult to organize aftercare and rehabilitation programs, some of which were designed in ingenious ways to enlist the help of family members,

neighborhood cadres and coworkers. Together they effectively monitored patients' clinical conditions, ensured adequate compliance (adherence) with pharmacotherapy, and tried to work in concert to modulate the level of stress for the patients. These experiences led to the development of model programs that were promoted and implemented in large geographic regions, such as in the greater Shanghai area (Yan and Zhang 1990; Pearson and Phillips 1994).

Although similar ideas are still being promoted, it is doubtful if many of the essential ingredients are still there. The gradual, but steady, loosening of social control means also that less social support is available. To the extent that neighbors and coworkers are less intrusive as compared to a decade or two ago, they also have become less involved and less accessible. Most importantly, clinicians are increasingly under financial pressure to generate profits for the hospital, which directly or indirectly affect their income. In such a situation, community care becomes a low priority, and previously established rehabilitation programs are now mostly in disarray. Paradoxically, while the society may be progressing rapidly in many fronts, a price to pay is that those who do not compete as well will get left behind, and their welfare and care will continue to worsen (at least in the immediate future).

Similar "market forces" may also have exerted an erosive effect on the infrastructure for research and for academic activities in general. A decade or two ago, newly emerging from the more than thirty-year period of intellectual isolation from the West, Chinese psychiatrists at major academic centers were most concerned about "catching up with the rest of the world," and were remarkably determined in their pursuit of new perspectives, knowledge and research skills. For a number of reasons, those "innocent days" are long gone. While the income of the professors has increased gradually over the years, it still lags far behind in comparison to those entering the newly emerging entrepreneurial world. As described by Dr. Lee, the arrival of multi-national pharmaceutical companies further complicates the situation. Funding from foreign sources holds disproportionate sway over the priority and orientation of research currently conducted in China. As a result, the interest and focus of the academic elites may have become progressively less rooted in the local clinical and social realities, and become relatively more at the mercy of the interests and whims from outside of China.

To be sure, none of these problems are inherently specific to the field of psychiatry and mental health, but significantly impact all segments of the society, including the whole domain of the medical establishment as well as the human services infrastructure. However, at times of rapid trans-

ition and uncertainties, fields that are traditionally regarded as marginal, or are stigmatized, are more vulnerable and thus more easily neglected or ignored. This is certainly the case in the U.S. to a certain extent: medical centers facing escalating financial burdens and dwindling resources may place much higher priorities on professions perceived as high profile and popular, to the expense of "peripheral" fields such as psychiatry.

CONCLUSIONS

The history of China in the last half century is truly remarkable, with a number of astounding reversals that have been sweeping and unpredictable. Throughout most of this epoch, psychiatry was either actively suppressed (as during the time of the Great Proletarian Cultural Revolution) or benignly neglected (Kleinman 1988; Pearson 1995). That psychiatry as a profession has continued to grow and prosper despite adversities and setbacks testifies to the tenacity and ingenuity of the leadership of Chinese psychiatry. Paradoxically, despite the superficial evidence of prosperity in the society as a whole, and the relative stability of the profession itself, the current crisis may be even more treacherous and subversive, precisely because it is more subtle and thus less threatening in appearance. The saying "crisis fosters opportunity" (derived from the Chinese term "Wei-Ji") has been used so often that it has become a cliché. However, optimal mental health care of one-fifth of the human populace is at stake. For this reason alone, it is important to point out the existence of the crisis, and to identify its potential sources. Dr. Lee's paper goes a long way in starting such an important process.

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