

# THE EXPERIENCE OF DISTRESS

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## ABSTRACT

This article examines the issue of distress as it affects men and women, in particular in relation to suicide and marriage. The paper draws on locally based, empirical data that shows that marital satisfaction increases for men the longer they are married, while decreasing for women. Although the overall rate of suicide is higher for men than for women, the two rates are much closer in Hong Kong than is the case in Western countries. This suggests that, among other things, marriage provides less protection against suicide for women than is commonly the case elsewhere. The article points out that because men's means of expressing distress tends to involve acting out behaviour, women and children are the focus of aggression, which increases their distress levels. The article concludes with evidence that demonstrates that approximately 60% of people who kill themselves in Hong Kong have consulted a doctor during the previous 14 days, suggesting that professional ability to recognise the variety of ways in which distress is communicated needs to be improved.

**Key words:** *Distress; Help-seeking Behaviour; Marriage; Suicide*

## INTRODUCTION

The editor of the *Hong Kong Journal of Psychiatry*, when he approached potential contributors for this issue, said that, as a guiding principle the article should be about something "close to our hearts". When I gave this some thought, the answer, sad to say, was distress. It is perfectly possible to be a social worker with an optimistic outlook on life in general and for clients in particular. Those working with young people or in community development projects frequently experience success; youngsters are reconciled with their parents or residents of squatter areas are re-housed in decent accommodation, for instance. However, my chosen field could not really be called the optimistic side of social work and it has consistently brought me into intimate contact with other people's distress in a myriad of contexts.

I have been a social worker since 1971 and for most of that time, as a practitioner or as an academic, I have been involved with people with a mental illness and their families. Consequently, I have spent a considerable amount of time over the years thinking about the phenomenon of distress, defined in this article as "severe pressure of trouble, pain, sickness or sorrow, anguish, affliction, privation, lack of money or resources".<sup>1</sup> I have also come to realise how inextricably our sense of the world and our place in it is bound up with being born either a man or a woman. This genetic accident of fate bisects all human experience, including the experience and manifestation of distress.

## THE EXPRESSION OF DISTRESS

In 1981, I was supervising a young female social work student (whom we will call Marion) in a family welfare centre

in Western district. She had just seen a 28-year-old male client who was a recent immigrant from China, who had come to live with his elderly mother in Hong Kong. They were having problems adjusting to each other, and he was having great difficulty keeping a job because of his violent temper. He was deeply frustrated that his skills were not recognised here and that he could not read Hong Kong Chinese. Marion reported to me after the session finished and she was in a state of shock. When I asked her what had happened she said that he had cried.

Having recently arrived from England, I saw nothing strange in this and clearly, my response, whatever it was, did not match with Marion's expectations. "But he's a man and Chinese men NEVER cry" she declared, in an attempt to help me grasp the enormity of the situation. Gradually, light dawned. This man had expressed his distress in a way that was not culturally acceptable for males and it was this, rather than his many problems, that had impressed my young student. To her credit, she had acted in a way that seemed entirely appropriate to the situation and had managed to suppress her shock and incredulity until her supervision session with me.

This example made an indelible impression on me because it was the first time that I was brought face to face with issues that have occupied me greatly since. They have to do with the legitimisation of the ways in which distress is expressed and how these vary across culture and gender. Frequently, during my years as a teacher, I have heard students tell me that "Chinese people never express their feelings in public", "Chinese people never discuss their family matters outside the family", and "Chinese people always avoid conflict". What was deeply puzzling to me was that I was being told one thing while experiencing

another. I was the repository of many confidences regarding very delicate family matters and personal experiences from friends and students. The papers are full of instances of family violence and the University of Hong Kong was no freer of the usual political games and conflicts than any other large organisation.

What came to trouble me, in terms of the therapeutic alliance, was whether my students actually believed that Chinese people really should restrain their behaviour in these stereotypical ways. If this was the case, then the subliminal message that they conveyed to clients would be one of clearly demarcated 'no-go' areas. Not because of the wishes of the client but because of the unacknowledged limitations of the therapists who, in essence, would be projecting their own fears about dealing with personal revelation onto the client.<sup>2,3</sup>

### LIVING IN A MOULD

Clearly, even if they are broken, there are still 'rules' about proper behaviour, which vary between men and women. Women, because they are expected to be weak and emotional, are permitted to cry in times of stress, grief, and frustration. Men are not. Instead cultural norms accept more aggressive ways of acting out, albeit in similar circumstances — cursing, shouting, and verbal (and occasionally, physical) abuse. Seminal research has been performed in the USA on the question of sex role stereotypes used by mental health workers. It was found that the more women behaved in ways that were considered mentally healthy for men (confident, assertive, taking on leadership roles) the more mentally unhealthy they were judged to be.<sup>4,5</sup>

Similar research was undertaken in Chinese populations with results that indicated even greater sex role differentiation in the Chinese populations.<sup>6,7</sup> Bond points out that sex role stereotypes are formed as a result of an individual's experience of interaction with people of both sexes and are not only based on biological differences between the sexes but also the relative social status of both sexes in a given culture.<sup>8</sup> Even though one may argue (as I would) that male stereotypical behaviours confer advantages, the burden of conforming to them is not necessarily beneficial. David and Brannon describe the stereotyped male role in terms of four dimensions:<sup>9</sup>

- No sissy stuff – the need to be different from women
- The big wheel – the need to be superior to others
- The sturdy oak – the need to be independent and self-reliant
- Give 'em hell – the need to be more powerful than others.

Being squeezed and twisted into behaviour considered appropriate according to gender stereotyping does nobody any favours — neither men nor women — and certainly does not contribute to good mental health. Indeed, because women have apparently dominated the mental ill-health statistics for so long, very little attention has been paid to the issue of the impact of the male role on mental health. This is despite the fact that it is becoming recognised that the way that men lead their lives contributes to their shorter life span.<sup>10</sup>

**Table 1. 'Common disorders' from the Sha Tin epidemiological study<sup>13</sup>**

Disorder	Male	Female
Pathological gambling	2.95	0.16
Generalised anxiety disorder	7.77	11.11
Alcohol abuse and dependence	8.88	0.62
Dysthymic disorder	1.05	2.83
Major depressive disorder	1.29	2.44
Antisocial personality	2.78	0.53
Obsessive compulsive disorder	0.87	1.22
<b>Total</b>	<b>25.59</b>	<b>17.69</b>

The Epidemiologic Catchment Area (ECA) Study, started in 1980 in the USA, was one of the first to challenge the belief that psychiatric disorder in the community was predominantly experienced by females.<sup>11</sup> Instead, the ECA Study showed that disorders in men are slightly more common than in women due to the decision to include substance dependence and personality disorder.<sup>11</sup> Another major study performed in the USA confirmed this finding; women were more likely to suffer from affective disorders (with the exception of mania, for which there was no detectable gender difference) and men more likely to have substance use and personality disorders.<sup>12</sup> Closer to home, Chen *et al*'s epidemiological study from Sha Tin confirms this trend.<sup>13</sup> This study found no gender differences in the lifetime prevalence of bipolar disorder, schizophrenic disorder, and schizophreniform disorder. However, the story was somewhat different when examining what Chen *et al*. call the 'common' disorders (Table 1).

### CULTURE, GENDER, AND DISTRESS

All these disorders are subject to (which does not necessarily imply causation) issues of social construction, in other words how a culture legitimises the expression of distress, which may be different for men and women. This is what Shorter has called the models that the culture holds out for the communication of inner distress.<sup>14</sup> There is, for instance, a continuing debate over the very low prevalence of depression and related disorders in epidemiological studies in Chinese societies, particularly China itself.<sup>15</sup> Yet even with a low general prevalence of depression, women in China are significantly more likely to be diagnosed as depressed than are men,<sup>16</sup> a tendency found in Western societies such as the USA and the UK.<sup>10</sup>

During the past 30 years or so, there has been much research demonstrating specific risk factors in women's lives that are highly related to social expectations and a lack of economic opportunities.<sup>10</sup> The foundation of these risk factors is women's lack of power economically and within the family. Tang demonstrated that there is a robust gender effect regarding the distribution of decision making power and the occurrence of aggression among married couples in Hong Kong.<sup>17</sup> This researcher concluded that the social institution of the Chinese family reinforces the dominance of men over women, and that any challenges to the system as a result of women's increased education and employment

opportunities will be met with repercussions in the form of marital violence.

However, there is a corresponding lack of research on the effect of male role expectations on mental health. From the figures given above it is fairly obvious that there are different models for the expression of inner distress. Female distress is turned inward and easily construed as a psychiatric disorder. Male distress, on the other hand, is acted out in different ways that relatively rarely bring men to the attention of doctors, let alone psychiatrists. We should not lose sight of the fact that male 'acting out' behaviour often means that women (and children) become targets and, thus, victims.

Robins and Regier found that the adult symptoms of antisocial personality (which they claim is characterised by the violation of the rights of others, and a general lack of conformity to social norms) are job troubles, violence and severe marital difficulties — all of which impact on family life.<sup>11</sup> Pathological gambling has consistently been found to be involved in wife abuse in both Hong Kong and China.<sup>18,19</sup> Nonetheless, these behaviours are still an expression of inner distress compounded by the cultural belief that acknowledging distress shows a weakness associated with women and therefore does not befit a man.

## SUICIDE

Some of these issues may be admirably demonstrated by looking at the issue of suicide in Hong Kong. Suicide fascinates in that it is at one and the same time the most intimate act a person can commit while also being subject to macro analysis that permits the identification and comparison of pressure points within and across societies. In Chinese societies, for instance, the elderly are at high risk for suicide.<sup>20</sup> In Australia, one of the highest rates of suicide is amongst young rural males.<sup>21,22</sup>

It seems reasonable to assume that such variations are an indication of cultural differences. It is well known that, with the major exception of China,<sup>23</sup> men commit suicide more frequently than women. This is also true in Hong Kong where the mean rate is 12.78/100,000 for males and 9.15/100,000 for females, or an approximate ratio of 1.4:1.\* Although this follows the worldwide pattern, in other countries males generally kill themselves at a rate three to four times that of females.<sup>24</sup>

It seems reasonable to suppose that men who kill themselves are distressed. They may or may not be mentally ill and the vast majority do not consult psychiatrists. Even if they are, they may not perceive themselves to be mentally ill. Do they seek help and if so, whose help do they seek? A very disturbing fact has emerged from a data set amassed for a PhD thesis on suicide in Hong Kong.<sup>24</sup> The data is based on police investigation reports of all deaths by suicide in 1992.

\* Throughout this article, suicide rates are expressed as per 100,000 of the relevant population.

**Table 2. Number of days between consulting a doctor and committing suicide and in two age groups and both sexes**

Age (years)	Male (%)	
	18 - 59 (n=296)	≥ 60 (n=154)
Up to 7 days	63.3	47.7
8 to 14 days	2.0	17.0
Total	65.3	64.7
Age (years)	Female (%)	
	18 - 59 (n=172)	≥ 60 (n=131)
Up to 7 days	50.0	53.9
8 to 14 days	16.7	17.5
Total	66.7	71.4

One of the questions police must ask routinely when investigating a death is whether the person had seen a doctor recently.

We can see from Table 2 that 65% or more of the total number of people who committed suicide in 1992 had consulted a doctor, usually a general practitioner, within 14 days of taking their own lives. In all but one group, more than 50% had consulted a doctor within seven days of taking their lives. For men in the younger age group this figure was 63%. According to the police records, based on interviews with family members, a minimum of 70% had no previous record of a suicide attempt, although family members had noticed deterioration in mood for about half of the victims. Clearly, those about to take their lives knew that something was wrong with them or they would not have consulted a doctor. They may not have had the words to express it clearly. They may even have believed that the doctor's diagnostic powers are such that they needed to say very little at all. There are no records of those consultations and we have no way of knowing the content or length of the communication between doctor and patient.

We may consider the possibility that distress was described somatically rather than psychologically. This is not infrequent in the local context. Equally, a degree of emotional distress, worries about money, family relationships and so on may have been shared. But doctors in general practice, who must be used to hearing such 'moans' may not consider them to be part of the information necessary to make a medical diagnosis. We do not know. But clearly there needs to be an improvement in the ability to interpret the patients' attempts to describe their inner world if this unnecessary loss of life is to be reduced.

## MARRIAGE

Marriage is generally thought to be a protective factor against suicide. The security and stability that (ideally) come with a sound marital relationship, the responsibility of children and so on are thought to anchor people more firmly to this world, despite all its troubles. It has been argued that the responsibilities and emotional benefits of marriage

are one of the reasons why women kill themselves less frequently than men. However, we have already seen that the male to female ratio for suicide is much lower here than in many Western countries. Yip's analysis of Hong Kong's suicide statistics supports the view that marriage provides less protection for women against suicide than it does for men.<sup>21</sup> Why?

It seems to be a common wisdom that marriage is an institution made for women. Traditionally, marriage has been seen as the equivalent of a career for a woman and the main task of a young woman is to make a 'good' marriage to a man who will be a reliable provider and a concerned father. In this scenario, women tend to be portrayed as 'weak predators' and men as 'strong victims'. Yet, there is evidence from overseas that this is the reverse of the facts; that indeed marriage benefits the health and well-being of men more than women.<sup>25</sup> Shek set out to test this proposition in Hong Kong by studying the gender differences in marital quality and well-being of married adults in Hong Kong.<sup>26</sup> This researcher found that males had higher marital satisfaction and adjustment scores than women.

Hong Kong married women were more negatively affected by marriage in terms of making a poorer adjustment and expressing lower satisfaction than men. Shek also found that the longer men had been married, the higher their perception of levels of 'dyadic consensus' and affectional expression i.e. the better they felt.<sup>26</sup> The longer a woman was married, the lower were her levels of marital adjustment and satisfaction. This clearly suggests that women get fewer benefits from marriage and have a generally more negative experience. In fact, they are losers in the relationship. Shek's explanations for these results are first that women have higher expectations and expect more in the way of intimacy than men are able to give,<sup>26</sup> and secondly, that male and female roles in marriage are different, with the roles of married females being more stressful and disadvantageous as well as less gratifying.

Halliday's figures (excluding those for people aged less than 15 years) certainly support the finding that marriage is more protective against suicide for men.<sup>24</sup> For males there is a reduction in the suicide rate from 25.5 (unmarried rate) to 10.9 (married rate; 57.4%). For women the reduction in rate is only from 12.2 to 8.7 (28.7%). The suicide rate for widowed males is 50.0 and 29.7 for women. The suicide rate for divorced or separated males is shockingly high, at 238.8, compared with 92 for females.<sup>24</sup> Based on the research of Yip, Halliday and Shek in Hong Kong, it is hard to conclude anything other than that men are the greater emotional beneficiaries in marriage, despite their frequent subjective perception to the contrary.<sup>21,24,26</sup>

## CONCLUSION

It feels a little strange, after pursuing women's issues for so long, to find myself arguing the cause for men. In my view it is quite clear that as long as both the general population and health care professionals buy into the socially constructed cultural imperatives about female and male behaviour, men,

in particular, are going to be isolated from the possibility of the help that they so clearly need and are being denied. As long as men's distress goes unrecognised and untreated, women and children will suffer.

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