

Neurasthenia Revisited: Psychologizing Precarious Labor and Migrant Status in Contemporary Discourses of Asian American Nervousness

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Neurasthenia—a term first coined by American neurologist George M. Beard in the 1860s—was a ‘malady of civilization’ associated with cerebral overpressure from the stresses of modern industrial life (Rabinbach, 1992:154). Many scholars of neurasthenia assume this psychopathological ‘disease of the will’ was a white disease that disappeared from Western medical practice since the early twentieth century. However, in this paper, I argue that not only has neurasthenia traveled to non-Western contexts, but that its genealogy as a culture-bound syndrome continues to haunt the present in North American cross-cultural counselling. Through a textual analysis of multicultural psychology textbooks published over the last decade, I argue these ‘traits’ serve to sequester problems of oppression into the private, apolitical space of family and culture, renarrativizing experiences of racial profiling, classroom segregation, worker disablement, and poverty as culturally determined mental health problems.

Keywords: Neurasthenia; *shenjing shuairuo*; introversion; somaticization; Asian immigrant families; racial governmentality; cross-cultural psychology; global mental health

Neurasthenia: A Traveling Diagnosis

In the 1860s, US neurologist George M. Beard first theorized neurasthenia as an excessive burdening of the brain, gastrointestinal, and/or reproductive organs. Symptoms included lack of concentration, sustained lassitude, digestive problems, and impotence (Beard, 1880). He believed this burdening was caused by the heightened pace of work in modern society. Historians, such as Schuster (2011), argue neurasthenia was a privileged diagnosis at the turn of the twentieth century. In *Neurasthenic Nation*, he notes the profile of the modern neurasthenic was American, white, and wealthy. Recommended therapies included rest cures prohibiting excessive labor and promoting travel, recreation, and complete leisure. Others, such as, Taylor (2001) assert that neurasthenia was not a discourse exclusive to upper class whiteness. In the UK context, neurasthenia was as much a diagnosis of the working classes.

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Quoting one annual report from Queen Square Hospital, 1894, Taylor (2001) notes that doctors believed the pressure on the lower middle classes and the poor to escape poverty and financial disaster contributed to an increase in cases of nervous diseases. Neurasthenic patients came from a range of occupations, including parlour maids and horn workers. Further variants included chronic war neurasthenia or ‘honestly acquired’ neurasthenia from military service, accompanied by shell-shock (Compston, 2013).

However, most iterations of neurasthenia shared something in common: symptoms were both somatic and psychic, and symptoms impaired ‘role functioning.’ For example, patients might have irritable bowels, irritable tempers, and consequently ‘avoid society’ (Compston, 2013:1683). Impaired role functioning was synonymous with impaired ability to work. Today, international psychiatrists equate the term functional impairment with ‘disability’ in the International Classification of Diseases (ICD) (Üstün & Kennedy, 2009:82). As Slijkhuis and Oosterhuis (2012) point out, symptoms of neurasthenia live on in chronic fatigue syndrome and have even been linked to neurobiological syndromes such as fibromyalgia (Paralikar et al, 2011). A disease that’s been ‘hard to define or delineate,’ neurasthenia continues to serve as an international nosological ‘catchall’ for problems with work productivity, independent living, and sociability over a century after Beard’s (1880) treatise on nervous exhaustion (Slijkhuis & Oosterhuis, 2012:80).

As sociologists and historians of science remind us, scientists often attribute disparities between social groups to racial biology, thereby circumventing critical analysis of relations of production (Duster, 2005). Yet scant literature interrogates racialized constructions of neurasthenia in the West and even less literature questions the diagnostic category’s more recent conception as a culturally determined illness in global psychiatry. In the humanities, neurasthenia is often the subject of history, seen as an anachronistic diagnosis. Even the Columbia Encyclopedia (2013, online) states ‘the term was incorrectly applied to almost any psychoneurosis and has been largely abandoned.’ Interdisciplinary scholars in fields such as Cultural Studies or Ethnic Studies unfamiliar with the history of neurasthenia often assume it is an antiquated diagnosis replaced by mental disorders such as depression or chronic illnesses such as fibromyalgia. They may be surprised to hear that psychiatrists continue to analyze the disorder’s prevalence across racial and ethnic groups in the US (Molina et al, 2012), debate its nosological criteria (Orsat et al, 2013), argue for its continued relevance in clinical practice (Yew Schwartz, 2002), as well as study its cultural epidemiology transnationally (Paralikar et al, 2011).

In this article, I trace the many lives of neurasthenia in order to demonstrate the multiple ways in which shifting constructions of this disorder helped placate historically specific anxieties about gender, race, and class. The first section of this article reviews historical accounts of neurasthenia as gendered and racialized forms of failed whiteness in the métropole, colony, and settler colony in places such as France, British East Africa (Kenya),

and the United States (Crozier, 2009; Briggs, 2000; Rabinbach, 1992). The second section explores how the disorder became attached to the Asian body—from Chinese coolies in early twentieth-century Lima (Drinot, 2004) to present day Indian women in urban Pune (Paralikar, 2011). I argue neurasthenia was and is problematically treated as a fungible disorder in places such as India, Japan, and China—used interchangeably with cultural concepts like Qi stagnation or *ki-utsu* in Japan (Daidoji, 2013). The Western concept of weakness, with its psychological connotations, began being treated synonymously with body idioms referring to political dissent against state violence and economic marginalization. Psychiatrists and psychologists (Western and non-Western) who use the language of neurasthenia to understand phenomena such as *shenjing shuairuo* in China, *ki-utsu* in Japan, and *ashaktapanna* in India, disregard the significance of these concepts as code for complicated local political-economic realities. For example, Kuriyama (1997) argues good circulation of *ki* was associated with the good circulation of capital. *Ki utsu* came to symbolize moral failure during the ongoing economic recessions of mid-eighteenth century Japan.

I suggest the tendency to equate local idioms for socioeconomic problems with the Western diagnosis of neurasthenia is tied to the label's connotations as a functional disorder. So long as functional impairment is uncritically used to gauge neurasthenia, the debilitating effects of gendered and transnational relations of production get reduced to this individual neurobiological/psychiatric disorder. After all, functional impairment in the Diagnostic and Statistical Manual of Mental Disorders (DSM) is used 'to mean limitations in the *social* and *occupational* spheres of life [emphasis in original]' (Üstün & Kennedy, 2009:83).

The third section of this article examines the transnational biopolitical repercussions of translating cultural concepts into neurasthenia. I explore how neurasthenia, now a culture-bound syndrome, travels back to the West as a contemporary Asian American disorder. No longer reflective of Beard's 'disease of modernity,' neurasthenia is now understood as a culturally specific experience of depression, in which particular communities (such as Chinese Americans) somaticize or euphemize mental health symptoms (Yew Schwartz, 2002; Lee and Kleinman, 2007).

Specifically, I trouble neurasthenia's present day diffusion into North American cross-cultural counselling. While cross-cultural therapists, such as Yew Schwartz, literally provide treatment to Chinese immigrants for neurasthenia, other Canadian and U.S. based practitioners apply its culturally specific symptoms more allusively through the frameworks of cross-cultural counselling. Also known as multicultural counselling or cross-cultural psychology, cross-cultural counselling employs strategies 'congruent with individuals' experiences and cultural values,' that 'appreciate the cultural and epistemological underpinnings of countries located worldwide,' and focuses on 'how culture affects behavior with [the] aim of developing an inclusive universal psychology' (Gerstein et al, 2012:6). Like transcultural psychiatry, cross-cultural counselling is concerned with paying careful attention

to patient's problems within their social contexts (Swartz, 2012). Indeed, given that counselling psychology as a whole addresses developmental life stresses, as well as family and group dynamics, it would seem that cross-cultural counselling is uniquely positioned to do so, unlike its classificatory, drug addling counterparts. However, 'social context' tends to be reduced to narrow and homogenizing rubrics of cultural identity and behavior, further marginalizing effects of racism and other oppressions on people's feelings and actions.

Through a textual analysis of multicultural counselling textbooks published over the last decade, I suggest that some symptoms of Chinese and Japanese neurasthenia have entered Asian American counselling discourse unproblematically as permanent behavior traits of Asian Americans. These include introversion, perfectionism, and psychosomatic 'weakness.' I argue that present discourse on the Asian American 'traits' of fatalism, forbearance, face, maladaptive perfectionism, and somaticization constructs life problems as mental health problems. Neurasthenic symptoms-as-traits marginalize real life experiences of racial profiling, classroom segregation, underemployment, wage theft, worker disablement, and poverty by reducing these structural problems to ethnopsychological characteristics.

I conclude by reflecting on the lingering inheritance of neurasthenia in cross-cultural psychology. In places such as China, Japan, and India, neurasthenia was/is a precarious translation of people's euphemisms for domestic abuse or unemployment. Today its 'symptoms' persist in the clinical literature as culturally specific, adverse coping mechanisms. Neurasthenia now haunts general descriptions of Asian American psychology, reinforcing culturalist rhetoric on Asian workaholicism. By studying the racial formation of neurasthenia, we see how the diagnosis not only traveled to 'other' cultures: neurasthenia supports and maintains colonial epistemologies of cultural difference.

Rehabilitating and Reproducing Whiteness in the Late Nineteenth and Early Twentieth Centuries

A cursory reading of the history of neurasthenia might tell you that it was a 'malady of civilization'—a uniquely American or European disorder related to changes in occupational health during a period of rapid industrialization and 'expansion' (Rabinbach, 1992:154). As such, it makes sense that Western historians of neurasthenia would assume neurasthenia was a narrative about imperiled whiteness. There are several accounts of this that enrich our understanding of neurasthenia as a calculated racial disease. For example, at the turn of the 19th century, neurasthenia was seen as a sign of atavistic regression in France. Ribot (1896) theorized that the stresses of civilization triggered a reemergence of primitive human traits in white Europeans. The etiology and prognosis of neurasthenia mirrored contemporaneous ideas about human evolutionary progress (Rabinbach, 1992). Various *types* and *stages* of neurasthenia carried different racial meanings, with serious cases (hereditary or chronically

debilitating forms of fatigue) taking on more atavistic qualities.

Ribot compared aboulia, a symptom of neurasthenia, to the impulses of savages. He also compared the impaired energy of his patients to Eastern spirituality, observing the motionless and mute behavior of mystics. Whether he described neurasthenia as a savage descent back into 'desire operating as a reflex' or as a mystical state 'lacking intentionality,' Ribot saw neurasthenia as a pathological resistance to work (Rabinbach, 1992:165,169). For French clinicians such as Ribot and Bouveret, neurasthenia was racialized twofold: both as a metaphor of savagery and otherness in the nervous degeneration of whites *and* as proof of racial inferiority in bona fide 'hereditary' neurasthenics such as 'Jews, and the slave race' (Bouveret, 1890:9).

Shifting from the center to peripheries of empire, limited scholarship also shows neurasthenia was a means of regulating white masculinity in the colonial context. Focusing on examples of tropical neurasthenia within the Colonial Service in British East Africa prior to World War II, Crozier (2009:546) documents how neurasthenia was a means of 'weeding out' men unfit for colonial duty and maintaining 'national strength.' Unique to Crozier's (2009:528) article is her attention not only to neurasthenia's connections to broken manhood, but also to homosexuality, where the Colonial Service's criteria of masculinity, fortitude, and resilience were set in direct contrast to neurasthenia's associations with 'excessive masturbation and homosexuality'.

Other scholars have documented the gendered dynamics of neurasthenia in settler colonial contexts. For instance, Briggs (2000) explores how neurasthenia served to warn against the perils of white women's increasing education and professionalization in the late nineteenth century United States. Subsuming neurasthenia under hysteria, Briggs (2000:247) argues hysteria 'and its variants neurasthenia and nervousness' were part of a discourse that identified middle and upper class white women as 'endangering the race through their low fertility.' Unlike the connections Ribot drew between weakness and idleness of savages, U.S. physicians juxtaposed the impotence of neurasthenic white women against the racial hardiness of African Americans, Indigenous peoples, and immigrants. This difference may be attributed to the nature of the work involved. While European men were diagnosed with neurasthenia for resisting the will to work, Anglo-American women were diagnosed with neurasthenia for resisting the will to procreate. And where savage men might be inferior to the colonizer's industrious nature, savage women threaten the colonizer with their uncontrolled fertility.

In summary, Briggs (2000) believes hysteria and neurasthenia only affected enervated, infertile white women, not savage women. She supports this claim through pointing out that many North American physicians, especially obstetricians and gynecologists, believed that Indigenous women and Black women did not suffer from hysteria because they gave birth

easily. According to Briggs, racialized women were resistant to pain—a belief that justified horrific medical experimentation on non-Euro-American women. Yet Briggs' sole focus on the *American Journal of Obstetrics* renders her claims about neurasthenia as a discourse of endangered whiteness ungeneralizable. In particular, the slippage between hysteria and neurasthenia proves to be problematic. Briggs (2000:268) explains, in a footnote, that while late nineteenth century physicians would distinguish between hysteria and neurasthenia, these illnesses were confounded even then, and that given the purposes of her study, the two labels 'were not sufficiently well-defined that in retrospect one could insist that these were differences that mattered.' However, elsewhere during this period, neurasthenia was not exclusively treated as a white, female reproductive disorder. By the early twentieth century, neurasthenia was introduced as a diagnosis in mainland China, at which point its racial subtext of white civility abated.

Orientalizing Neurasthenia: Western Diagnostic Approximations of Non-Western Disorders and Social Complaints

While Anglo-American women were diagnosed with neurasthenia for their misguided labor and failure to reproduce a white settler population, Chinese and Japanese doctors began adopting neurasthenia from the West to diagnose liver and kidney disorders. It's important to understand that both communities were disinterested in neurasthenia's purely psychological connotations. Mental symptoms were explained first and foremost through a person's constitution (as opposed to their 'lack of will'). Chinese and Japanese doctors saw similarities between the Western diagnosis of neurasthenia and conceptions of human physiology in Traditional Chinese Medicine (TCM) and Kampo. For example, early twentieth century Chinese translations of 'neurasthenia' were consistent with principles of Qi or life force in TCM. The concept 'nerve,' so central to Beard's original formulation of neurasthenia as a mechanical weakness of the nerves, was translated to *jingmo* or 'energy channels.' German diagnostic profiles of neurasthenia bore similarities to Chinese descriptions of *xulao*, i.e. depletion disorder (Shapiro, 2000). German theorizations of neurasthenia also warned about the dangers of excessive masturbation, a belief shared by the ancient Chinese alchemical practice of *huanjing bunao*. Consequently, Chinese physicians began referring to cases of fatigue, listlessness, insomnia, and seminal emission as neurasthenia or *shenjing shuairuo* during the 1930s.

In contrast to the connections TCM drew between neurasthenia and the depletion of Qi, Kampo doctors saw neurasthenia as the stagnation of Qi or *ki* and the accumulation of inner poison. At the turn of the twentieth century, Mori Dōhaku posited that *ki* constraint or *ki utsu* produced three major poisons: stagnant blood, food poison, and water poison (Daidoji, 2013). Each of these poisons could lead to various diseases with mental and physical symptoms. For example, insomnia, headache, and loss of appetite were all evidence of liver poison. Mori's

pathology was treated through proper eating habits, daily hygiene, and herbal formulas. It was only doctors like Morita Masatake who linked neurasthenia to personal disposition or emotion and behavior. Even so, Daidoji (2013) urges us to situate connections between *ki-utsu* and emotional disorders within a Japanese history of *ki* as a metaphor. For example, during the Edo period, stagnation of *ki* ‘was often considered a manifestation of the lack of hard work and the failure to nourish life’ (Daidoji, 2013:64). *Ki-utsu* became a method of morally condemning numerous uprisings during the severe famines and ongoing economic recessions of mid-eighteenth century Japan.

Likewise, *shenjing shuairuo* held a double meaning in China. It both referred to the physiologically disordered flow of Qi and a figuratively ‘disordered’ populace. Shapiro (2000) argues that Chinese teachers, professionals, and laborers began remaining at home complaining of neurasthenia due to disillusionment with the revolution. In the 1950s and 1960s, neurasthenia became a strategic medical complaint used to resist political violence and express collective opposition. The significance of Japanese *ki* constraint and Chinese Qi depletion as idioms for state oppression and civil protest is often overlooked. A similar thing could be said about neurasthenia in early twentieth century Peru. While some historians continue to link the rise of neurasthenia in non-Western contexts to the ‘belated’ development of the global South—prescribing, once again, narratives of nervous exhaustion caused by rapid industrialization—few pay attention to the marginalized workers whose oppressive conditions are erased through the diagnosis of neurasthenia.

For example, Drinot (2004) notes neurasthenia was used to construct the suicides of Chinese migrant workers in Lima as the inevitable product of biological determinism, as opposed to the brutal consequences of indentured labor. Physicians such as Sabino Ríos believed degenerate workers did society a favor by eliminating their weak bodies from the species. Other physicians believed suicide could be fought through strengthening a love of work to combat laziness (Drinot, 2004). In short, medico-legal explanations for suicidal death ‘helped to dilute guilt and responsibility by apportioning blame to forces of a psychological nature over which no one had real control’ (Drinot, 2004:109). Thus, the suicides of racially degenerate Chinese coolies could be seen as an unavoidable effect of modernization in Lima, instead of a form of self-killing that was a response to a dehumanizing economic system of exploitation. Today, the biologization of suicide continues to support the violence that is inherent to global capitalism, as Mills (2014) documents in her discussion of the overmedication of farmers in India with antidepressants.

India is also an example of one country where the symptomatological resonances and medicalizing capacities of neurasthenia continue to pervade in the present moment. In Pune, doctors are labeling patients with a neurasthenia spectrum disorder (NSD) when most patients refer to their problems using expressions rather than ‘names,’ with the most common being *ashaktapanna* or weakness (Paralikar et al, 2011:270). Paralikar et al (2011) seem to

disregard the fact that this might be because patients are presenting problems related to the life course that are often physiologically (childbirth, menopause) and socially gendered. For example, patients frequently reported worries such as ‘Who will look after me?’ ‘How will I cope with life without any support?’ (Paralikar et al, 2011:270). While the authors fail to elaborate on the contexts for these worries, these complaints appear relevant to questions of access to social services like elder care and reflect gendered and classed dynamics of reproductive labor. Where Paralikar et al (2011) do provide examples of patient narratives, they frequently address women’s experiences of domestic violence and oppressive household duties. It would seem the diagnosis of NSDs reduces structural oppressions to ‘conditions of distress.’

This is complicated by the fact that patients request additional medical testing and investigation. For example, Paralikar et al (2011) cite one rural woman laborer who requested a full body scan and tablets to make her well. The authors use these help-seeking patterns to legitimate the clinical significance of NSDs. To return to my earlier discussion of the significance of ‘functional impairment,’ I believe that working in sectors such as Pune’s automotive industry excessively demands the self-cultivation of employee health. It should come as no surprise that the majority of their patients reported ‘somatic complaints,’ in a city where the majority of low-wage labor exists in hazardous manufacturing jobs.

One oft-cited reason for neurasthenia’s popularity in Asian countries is its less stigmatizing nature compared to ‘real’ mental disorders such as schizophrenia and depression. This is a reductive and highly racialized interpretation of neurasthenia as means of ‘saving face’ or protecting one’s honor. Implicit in this interpretation is the assumption that maintaining respectability is bad (a sign of oppression) and seeking psychiatric help is good (a sign of liberation). As the case in Pune shows, the ‘prevalence’ of neurasthenia has little to do with the stigma of mental disorders. It’s more likely that patients merely see psychiatry as irrelevant to their problems. Instead, local service providers trained in global mental health see apparent similarities between neurasthenia’s emphasis on weakness or fatigue and local expressions such as *ashaktapanna*, substituting one for the other in clinical research and practice. In the process, the sociopolitical and economic significance of these idioms are lost. Where Western medical practitioners do acknowledge these expressions as cultural constructs, they reduce them to ‘idioms for distress’ (Kleinman, 1991). Here, distress serves as another euphemism for mental health problems (psychological distress), rather than problems of workplace disablement or lack of social services and structural supports. In summary, I argue neurasthenia’s emergence as a culture-bound syndrome is due to symptomatic readings of non-Western idioms for social distress. In countries such as China, Japan, and India, neurasthenia became a biomedically accepted translation of local expressions for political oppression, disillusionment and dissent.

It’s important to take this genealogy of neurasthenia into account as we examine its

reappearance in North American cross-cultural counseling. Recent statistics suggest that Asian Americans have higher rates of psychopathology than continental Asians (Yang & WonPat-Borja, 2007), and that neurasthenia is no longer a prevalent diagnosis globally, except in the Chinese diaspora (Yew Schwartz, 2002; Lee & Kleinman, 2007). One theory is that immigrant newcomers experience acculturative stress and become ‘mentally ill’, i.e., racism and oppression cause mental illness. Instead, I suggest that Western service providers import doctors’ mistranslations of foreign expressions for social problems, further reifying the belief that Asians customarily express their psychological problems through the language of weakness or fatigue.

In this article, I investigate how symptomatic readings of ‘custom’ persist in the West, where cross-cultural counselling psychologists inscribe all human action within a rubric of deep-seated cultural habits. I argue this occurs through the uncritical application of traditional symptoms of neurasthenia in mental health outreach with Asian immigrant populations. North American practitioners forget that Chinese, Japanese, and Indian symptoms of neurasthenia historically originated from uneven exchanges between Western and non-Western medicine—that Kampo doctors were under pressure to equip their practices with a ‘scientific’ outlook (Daidoji, 2013:76). They forget that neurasthenia was systematically superimposed onto problems that Chinese, Japanese, and Indian health providers encountered among their patients—problems that extended beyond the purview of medicine. As we saw in Pune, medical interventions became the only recourse for workers whose conditions of employment were unlikely to change in the short-term.

One unintended consequence of this dehistoricized usage of neurasthenia is the continued erasure of Asian experiences of oppression in the diaspora. Just as neurasthenia’s introduction in Asia led to abstract nominalizations of people’s concerted actions, so has its reintroduction in the West as a culture-bound syndrome and culturally specific behavior traits. In linguistics, nominalization refers to the conversion of nouns into verbs. In psychiatry and psychology, symptoms are examples of nominalizations. Nominalizations suppress ‘connectives of meaning’ (Smith, 1983:354). I argue that current discourse on neurasthenia helps to maintain the state’s differential treatment of people on the basis of race through symptomatic nominalizations of immigrant experiences of structural oppression.

Theorizing Race and Mental Health: The Biopolitics of Diagnostic Inclusion

In order to understand the power relations of cross-cultural mental health, it is necessary to first outline Foucault’s (2003) theories of biopolitics, biopower, and governmentality. Biopolitics is the style of government that differentiates the population into different groups for distinctive ‘ends.’ The state accomplishes this productive arrangement through biopower and governmentality. Biopower refers to various techniques for protecting and manipulating

life (actuarial science is an example of this ‘regularization of life’ [Foucault, 2003:249], where statistical risk assessments determine different people’s access to health insurance). Governmentality describes the complex processes by which people’s actions: 1) become problematic; and 2) become amenable to intervention. In cases where the government intervenes in bodily health and wellbeing, we can see how the concepts of biopower and governmentality overlap.

Cross-cultural mental health is one instance of biopolitics. Race-specific mental health diagnosis and treatment are examples of the differentiation and manipulation of racialized populations. In cross-cultural mental health, race-specific ‘psychological states’ are not only constructed as ‘natural’ (made ‘true’), but optimal (strategic truths). In other words, experiences of oppression are not only naturalized as ethnopsychological characteristics or culturally specific symptoms and behaviors; injustice is also reinforced by the very goals of recovery. The biopolitical capacity of mental health cannot be understated. For example, in the Canadian military, the diagnosis of post-traumatic stress disorder (PTSD) ‘literally manage[s] the disorder of soldiers,’ reducing conscientious objection to the military into nothing more than an acting out of symptoms (Howell, 2011:148).

Treating ‘Illness,’ Pathologizing Revolt

In the case of cross-cultural mental health, diagnostic categories not only redirect, but also limit the agency of racialized populations. Scholars in the U.S. have documented the ways in which psychiatric knowledge has reproduced and maintained racial hierarchies at critical moments of counter-hegemony. For example, Metzl (2009) asserts that the 1968 revision of the diagnostic criteria for schizophrenia, from problems of emotional disharmony to problems of intellect, was a historically codified way of controlling blackness catalyzed by the Black Power movement (see Cohen, in this volume, for a discussion on how this is played out in the pathologization of Maori resistance). He supports this assertion through content analysis of articles from leading psychiatric journals published between 1950-1980, focusing on the emergent ‘label’ of paranoid schizophrenia and the construction of ‘protest psychosis’ led by New York psychiatrists Bromberg and Simon. Their research on African American patients mirrored national conversations that linked blackness, madness, and civil rights, facilitating the institutionalization of black men in revolt.

Using an intersectional framework, Metzl (2009) recognizes how race has contributed to the development of mental illness diagnoses, but does not call into question the stability or validity of the illness model as a category of analysis to begin with. For example, he concludes that some individuals are misdiagnosed, which ‘locks the most needy patients outside the clinic gates so that they cannot even obtain treatment in the first place’ (Metzl, 2009:192). I challenge his firm ontological commitment to treating ‘illness’ that, in his view,

is simply ‘stigmatized’ due to historical bias (Metzl, 2009:212). By essentializing the tools of health, which are themselves social, Metzl reproduces the same structural violence he critiques in his analysis of cultural competency. To Metzl, race simply misguides, rather than constructs, our understanding of mental illness. I argue race and madness, or mental disorder, ‘become’ together, co-constituting one another, and as such are irreducible to subjective desires or gridlocked social categories.

Metzl’s genealogy of paranoid schizophrenia explores the epistemological transformation of race-specific experiences of social difference and oppression into race-specific mental health symptoms, highlighting the emergence of a new and distinct racial pathology. In the following analysis, I do the opposite. I explore the trans-pacific seepage of race-specific symptoms into the North American contemporary counselling psychology discourse on race-specific personality traits. I argue that traditional ‘symptoms’ of Asian neurasthenia persist as general cultural characteristics in the literature on Asian American psychology.

From Symptoms to Traits

Besides the contemporary revival of neurasthenia as a culture-bound syndrome in North American cross-cultural mental health (Yew Schwartz, 2002), symptoms once characteristic of Chinese and Japanese neurasthenia also surface in textbook literature on cultural traits, also known as culturally-based variables (Zane & Yeh, 2002); cultural meanings, processes, and practices (Yang & WonPat-Borja, 2007); cultural values, orientations, and behavior patterns (Sue & Sue, 2003); and cultural coping strategies or assets (Yeh, Borrero, et al., 2011). Of the traditional symptoms of Chinese and Japanese neurasthenia, three clusters remain prevalent in contemporary studies of Asian American behavioral traits: introversion and self-consciousness, perfectionism, and physical weakness or pain. They appear in studies about fatalism and forbearance, maladaptive perfectionism, and somaticization, respectively.

Before I proceed, I wish to acknowledge that the range of racialized populations grouped under ‘Asian American’ varies from text to text. Across the sources I analyzed, this includes the generous acronyms APIA (Asian and Pacific Islander), as well as AAPINH (Asian American, Pacific Islander, and Native Hawaiian) (Mio, Nagata, et al., 2007; Yeh, Borrero, et al., 2011). More often than not, however, the ‘Asian American’ traits I examine are associated with populations of East Asian descent (Zane & Yeh, 2002), and Chinese Americans especially (Fung, et al., 2011). The lack of symmetry across authors’ definitions (who is Asian?) leads to problems with the reliability of their conclusions. The haphazard grouping of people by phenotype or continent also homogenizes the very different historical relationships Chinese Americans, Filipino Americans, Arab Americans, and Native Hawaiians have to the U.S. and to each other. Hegemonic definitions of Asians as East and Southeast Asian specters of yellow peril—as mobile, hardworking immigrant expansionist threats to white settler

colonialists—shape the imagined racial/pathological subjects in these texts. This not only erases the actualities of working class ‘Asians’ with or without precarious status, but also the murderous and genocidal ways in which settler colonialism and counter-terrorism structure the lives of Native Hawaiians and Muslim Americans.

There are several ways in which I conceptualize cultural traits in the following analysis. Viewed as an assemblage, I believe the turn from symptoms-to-traits renders the Asian body perpetually sick, as what were once seen as features of an isolatable nervous disorder are now the features of a nervous race. With the exception of Yeh, et al. (2011), all of the texts I analyzed clearly connect practitioners’ lack of cultural sensitivity to the underdiagnosis of psychopathology. The paradigm of symptoms-as-traits assumes that cultural difference is emotional difference, as opposed to political difference. For example, Yang and WonPat-Borja (2007:380) define culture as ‘a process by which everyday activities become embedded with emotional meanings for actors in local worlds.’ Importantly, this definition does not capture the power relations that unfold in everyday activities. Instead, culture is constructed as a subjective pattern of emotional responses to particular activities. Yang and WonPat-Borja marginalize issues of privilege and oppression from their conceptualization of intercultural conflict, relying on culturally specific emotions as the dominant explanatory framework. As an instance of governmentality, the problematization of power vis-à-vis emotion directs Asian Americans to take responsibility for their own oppression.

We can see this insidious form of racial governance in Mio, et al.’s (2007) problematization of the model minority stereotype in their chapter on racism against Asian and Pacific Islander students. Model minority refers to the insidious assumption that Asian Americans are successful in North America by virtue of hard work and perseverance. It is a form of racial framing that both exalts Asian Americans in comparison to their ‘less successful’ African American and Latin American comrades while simultaneously perpetuating anti-Asian racism (Chou & Feagin, 2010). The term ‘model minority’ was first coined in 1966 in direct response to civil rights unrest. At first, Mio, et al. (2007) make the legitimate point that this label ignored the fact that despite some degree of success, more APIAs historically lived further below the poverty level than white Americans, adding that academic achievement rarely translated to job security. They support their claim by noting APIAs continue to be underemployed. The authors subsequently conclude the model minority stereotype masks the ‘needs of the community’ (Mio, et al., 2007:344). However, they focus on the symptom rather than the source of APIA distress, reducing the ‘real needs’ of Asian and Pacific Islander youth to ‘a wide range of mental health issues’ (Mio, et al., 2007:344). Mio, et al. thus eclipse the pervading political and economic effects of racial stereotypes in favor of a psychological analysis.

We can think about Mio, et al.’s (2007) treatment of poverty and unemployment as one degree of separation in social support: rather than intervening in U.S. economic policy, they

acknowledge the stress of barriers to ‘success’ (ex. racial justice). Taken a step further, the literature on fatalism and forbearance, maladaptive perfectionism, and somaticization represent two degrees of separation in social support. These traits are all theorized as unhealthy responses to ‘stress’ (ex. social distress). As a problematic, rationale, or explanation, the logic of cultural traits does not suggest that Asian Americans should suffer less; it demands that Asian Americans should suffer better.

While this article focuses on Asian American counselling discourse, I first encountered this literature in the Canadian context at a major research university while questioning and investigating the history of neurasthenia. It’s important to note that cross-cultural practitioners are in conversation with one another across the border and travel and work between both states. The ethnic behavior traits I describe in this article, such as perfectionism, also circulate at agencies such Hong Fook, serving East and Southeast Asian women in metropolitan Toronto. As such, my analysis has implications across both Canada and the U.S. I also drew on empirical examples from both contexts to further build a North American framework for understanding the significance of racialized neurasthenia as a Western phenomenon.

The Three “F’s” of “Group Harmony”: Face, Fatalism, and Forbearance

According to mental health experts, Asian Americans use collectivistic coping strategies: they place the needs of their group first and seek support from within their families and communities. Asian American children are expected to ‘assist, support, and respect their family’ and ‘behave well’ (Sue & Sue, 2003:331). Face, fatalism and forbearance are some examples of Asian American collectivism. These worldviews help Asian Americans deal with ‘culture-specific stressors, such as immigration and racism’ (Yeh, Borrero, & Kwong, 2011:119). Fatalism is the acceptance of one’s problems and an attempt to ‘shift one’s role or self to fit the situation rather than trying to change or control the environment’ in order to cope with ‘significant losses’ and ‘traumatic events’ (Yeh, Borrero, & Kwong, 2011:109). Forbearance is the related behavior of sacrificing one’s own needs for those of others by ‘keeping problems and feelings to oneself’; it is a ‘willingness and ability of a person to forbear his or her desires, problems, and emotions...for fear of...disrupting social harmony’ (Yeh, Borrero, & Kwong, 2011:109-110). Like fatalism and forbearance, ‘face’ is assumed as serving to ‘maintain group harmony’ in East Asian cultures (Zane & Yeh, 2002:126). The difference lies in the social context for these behaviors. Fatalism and forbearance represent the personal acceptance of misfortune. Fatalistic individuals wish to conceal their problems from others inside of the family, whereas face represents a person’s performance of one or more approved social attributes. Those who ‘save face’ wish to conceal their problems from others outside of the family. One difficulty with the literature on forbearance and face is the assumption that collective action is a misguided cultural behavior that cannot constitute

informed, healthy decision-making. Like Mahmood (2004), I challenge the Western secular-liberal assumption that agency must always take the form of self-mastery and autonomous free will. I suggest that ‘cultural conventions’ are not antithetical to an expression of true desire or resistance.

The culturally specific traits of face, fatalism, and forbearance bear resemblance to 1930s and 1940s Japanese definitions of neurasthenia ‘due to constitutional factors’ (Lin, 1989:110). In early twentieth century Japanese psychiatry, neurasthenia was categorized into four types. The fourth, *shinkeishitsu* or nervousity, included people with personality traits such as introversion, sensitivity, and inferiority (Lin, 1989). The idea that introversion—the quality of being more reserved and less outspoken—is not only abnormal and pathological, but a defining symptom of neurasthenia in East Asians, still fascinates Asian Pacific mental health researchers today. In 2009, a team of psychiatrists at Central South University in Changsha, Hunan, China conducted a study on possible psychosocial and immunological correlates of neurasthenia (Cao, et al., 2009). Their study found that the group of patients diagnosed with neurasthenia had higher scores for introversion and neuroticism than the control group. It seems qualities we call ‘introversion’ continue to be pathologized and overdiagnosed as neurasthenia. In this article, I argue that introversion is no longer yoked to the Asian neurasthenic exclusively, but to the Asian American body and community more broadly in contemporary Asian American counselling psychology.

Fatalism and forbearance: Significant silences

Yeh, et al. (2011) provide two case examples of Asian Americans who rely on fatalism and forbearance. The first is the story of Sen Ying, a third grader and immigrant from Fujian province in China. She feels lonely and sad: she misses her father who is rarely home and feels alienated at school where she gets ‘pulled out of class for one hour each day to work on her English with a specialist’ (Yeh, et al., 2011:117). Sen Ying’s beliefs are constructed as an example of fatalism: ‘she...is...beginning to see her problems as out of her hands and something she must accept as part of her new life in America’ (Yeh, et al., 2011:117). The authors argue this form of fatalism is a cultural belief, spiritually grounded in Buddhist and Taoist philosophy, which tells us ‘we should not interfere or manipulate social harmony’ (Yeh, et al., 2011:118). The second story is of Kalan, a Native Hawaiian who experiences racial segregation in his science class. In his first lab assignment, he is placed in a group with other Native Hawaiians at the back of the classroom that does not receive any equipment. Kalan also witnesses the racial profiling of a group of Native Hawaiian teenagers. He avoids telling his parents about both incidents. The authors believe his secrecy at home is an example of forbearance: ‘he does not want to disrupt the harmony he feels at home’ (Yeh, et al., 2011:116).

Both case studies imply that AAPINH cultures and religious beliefs make AAPINH youth more susceptible to internalizing oppression and remaining silent. I argue this reading of AAPINH silence minimizes the reality of racial segregation in schools by suggesting ‘acceptance’ is cultural and not circumstantial (for example, as the result of especially oppressive conditions). We learn very little about the kinds of traumatic events these different populations have historically endured. For example, we know that Sen Ying feels isolated at school as an English language learner, which is compounded by her removal from regular class time to work with an English as a second language (ESL) teacher. What we do not know is the extent to which racial segregation at the classroom level leads to the serious denial of educational opportunities—both for Sen Ying and Kalan. For example, earlier research in Britain reveals that the assignment of bilingual South Asian students to ESL programs leads to their disproportionately high presence in low ability streams, sets, and vocational courses, ‘almost with impunity’ (Troyna & Siraj-Blatchford, 2006:9). Rather than investigating the politics of ESL placement, Yeh, et al. (2011) theorize that Sen Ying has accepted her experiences of alienation because she does not want to interfere with Buddhist or Taoist notions of fate.

Yeh, et al. (2011) also discount the possible power of silence. For example, the national activist organization ‘INCITE! Women, Gender Non-Conforming and Trans People of Color Against Violence’ describes the power of quiet observation in the form of copwatches. In their toolkit *Law Enforcement Violence Against Women of Color & Trans People*, INCITE! note that copwatches, the filming and documentation of police behavior by a group of people, have been used to capture the experiences of young men of color, such as the adolescent Native Hawaiians in Kalan’s story. INCITE! (n.d.:54) explains, ‘[i]f police are being observed, they often tend to change their behavior,’ and consequently, copwatches can help prevent law enforcement violence. Revisiting Kalan’s relationship with his family, readers know nothing about his parents’ own activities and his reasons for not sharing. Perhaps the racism he encountered first and secondhand is all too familiar to his parents. Perhaps racism is so embedded in their everyday realities that it is news simply not worth mentioning. Or, perhaps his family is already organizing small acts of resistance through refusing to disclose information to the police about other community members. This would challenge the assumption that Asian American families are ‘collectivist’ out of ‘shame,’ as the belief that some ‘issues should stay in the family’ may very well be for the legal protection of family and community members (Sue & Sue, 2003:339). Perhaps Kalan is quietly documenting what he sees. Nothing about his actions necessarily suggests he is sacrificing his needs to preserve family harmony and there is nothing about his parents that suggests they live in a state of naiveté. On the contrary, a series of conscientious actions against institutional violence may serve as the context for his supposed ‘forbearance.’

‘Face loss’ and ‘face work’: Stigma versus status

Fatalism and forbearance are examples of some of the conceptual frameworks that cross-cultural mental health specialists use to understand how Asian Americans experience and respond to their social environments, while face loss and face work are examples of how these conceptual frameworks translate into therapeutic interventions. Echoing the traditional ‘symptoms’ of neurasthenia in Asian cultures, Zane and Yeh (2002:129) define losing face as the experience of self-consciousness about social status: ‘individuals who are simply too concerned about what others think or feel about them.’ They advocate the inclusion of relation-centered constructs such as face loss in clinical assessments, in the hopes that psychologists will better understand the motivations of their East Asian clients, meaning East Asian feelings and behaviors may be motivated by shame, rather than personal needs. Zane and Yeh (2002:126) believe shame prevents Asian American clients from seeking help for mental health problems because mental illness is ‘highly stigmatized...in their communities and families.’ In other words, loss of face correlates to a lack of openness to professional counselling (Leong, et al., 2011). In response, they recommend psychologists do ‘face work’ in therapy to minimize Asian American fears of ‘sharing their most private thoughts and feelings with a stranger’ (Zane & Yeh, 2002:134). The goal of face work is to eliminate the fear and shame associated with common face-threatening situations in the areas of social status, ethical behavior, social propriety, and self-discipline (Zane & Yeh, 2002).

Embedded in the concept of ‘face’, is the assumption that cultural fears of embarrassment and shame explain the high premature termination rates and short treatment stays of Asian Americans in mental health systems (Sue, et al., 1994). Zane and Yeh do not entertain other explanations for reservations about treatment. Besides the possibility that East Asians use different forms of non-professional support, I suggest concerns about self-disclosure in mental health settings are also rooted in patient awareness of the legal repercussions of having a psychiatric history, especially in the case of immigrants who do not have permanent residency.

The Precaritization and Pathologization of Migration

Gorman (2012) and Kanani (2012) have explored how the precaritization of migration means that workers cannot afford to disclose physical or mental disabilities without jeopardizing their immigration applications and work permits in Canada. At a roundtable discussion in 2012, Kanani shared one such story in which a woman living in Canada with her two sons applied to emigrate officially as a Federal Skilled Worker (FSW). During this time both her sons were labeled with psychiatric disabilities and as a result the government denied her family status and issued a deportation order. She later attempted suicide. Eventually they left the country.

Kanani (2012) notes that in 2010 alone, almost 1200 applicants were deemed inadmissible to Canada because they posed an excessive demand on health and social services. In the US, the Center for Disease Control and Prevention's (CDC) *Technical Instructions for Physical or Mental Disorders with Associated Harmful Behaviors and Substance-Related Disorders* provides instructions on how to determine if an applicant to permanent residency is inadmissible due to risk of dangerousness. The CDC (2010:13) provides a list of mental disorders most frequently associated with harmful behavior. Interestingly, this list consists of all 'major mental disorders', including major depression, bipolar disorder, and schizophrenia. In general, applicants with any of these diagnoses will not qualify for permanent resident status. This is because, according to the CDC (2010:9), past, present, and future harmful behavior associated with the majority of 'mental disorders' warrants Class A inadmissibility. If there is any 'evidence' that establishes that an applicant with a psychiatric disability was, is, or might be harmful, such as evidence of attempted suicide, they can be deported. Applicants may apply for a waiver of inadmissibility if they can demonstrate they are being adequately treated (medicated) and on the road to remission. However, noncitizen access to subsidized health insurance in the USA is limited (Galarneau, 2011; Nessel, 2012) and medication is becoming increasingly expensive, meaning that an application for a Class A waiver is unlikely. Given the increase in deportations during periods of rising unemployment (King, et al., 2012), it may come as little surprise that East Asian immigrants wish to maintain 'face' and limit the sensitive information they disclose to medical authorities.

Maladaptive Perfectionism: Constructing Parent-Child Alienation

Besides its connections to preserving social harmony, the concept of face is also cited in discussions on Asian American perfectionism - one of the original symptoms of neurasthenia in Japan (Yew Schwartz, 2002). Fung, et al. (2011) note that Asian American students in general have higher grade point averages, despite research that suggests Samoan, Cambodian, Laotian Americans and Native Hawaiians are not as highly successful. This is undercut by what they refer to as the 'achievement/adjustment paradox': these same overachieving students exhibit 'poorer psychological functioning' (Fung, et al., 2011:181). They explain that this phenomenon is the result of emphasis on academic success in Asian-origin cultures, where 'poor performance results in *loss of face* for the family [emphasis mine]' (Fung, et al., 2011:181). Families immigrate to provide better opportunities for their children. In return, their children internalize the need to repay parental sacrifice.

The authors note that this style of thinking can lead to a condition called 'maladaptive perfectionism,' which is characterized by fear of failure and excessive concern over mistakes (Fung, et al., 2011:182). They also state that maladaptive perfectionism increases Asian

American risk for depression and suicidality. Finally, the pressure to excel can cause open resentment, alienation, and physical violence between parents and children. In summary, Asian American students overemphasize the importance of academic success, which leads to anti-social behavior, depression, and dysfunctional family relationships.

To begin unpacking the narrative of maladaptation, and specifically maladaptive perfectionism, we need look no further than the word itself: maladaptive. According to the New Oxford American Dictionary (2010, online), the etymology of the prefix ‘mal-‘ is from the French *mal* or Latin *male*, which means ‘badly’; maladaptive means ‘not adjusting adequately or appropriately to the environment or situation.’ By labeling Asian American work habits as ‘maladaptive’, Fung, et al. (2011) imply that Asian American students must accept that their goals (of ‘perfection’) are not only unattainable—they are unhealthy. I argue the pathologization of Asian academic goals as ‘unattainable’ serves to reinforce the historical exploitation of Asian labor by assuming it is Asian workaholism, not labor market conditions, that produce experiences of isolation and intrafamilial alienation. Parents are held responsible for overemphasis on academics, when it is no fault of their own that their better-educated children may end up underemployed.

Fung, et al. (2011) suggest that hours spent studying prevent parents from nurturing family relationships, when it is transnational labor migration that literally explains the physical and emotional distance between parents and their children. To elaborate further, undocumented workers ‘do not push for their rightful earnings for fear of drawing the attention of immigration officials’ (Svoboda, 2011:para. 3). Undocumented workers’ everyday experiences of wage theft suggest that a significant number of Asian American parents will have less time to spend with their children due to working overtime as a result of their non-citizenship status. Other parents, still, have no time as a result of family separation. In her study of migrant domestic workers, Parreñas (2001) explores how the purchase of Filipino women’s reproductive labor separates Filipino mothers from their families. International free trade agreements are responsible for the flow of labor from poor to richer countries (Meghani & Eckenwiler, 2009) and this, in turn, alienates undocumented and temporary migrant workers from their children. As I argue elsewhere, the narrative of Asian American workaholism reduces family quality of life and intergenerational relations to cultural habits, and thus, erases histories of class struggle and lack of access to education (Chatterjee, et al., 2012).

Rather than acknowledge the above structural mediators to childcare, Fung, et al. (2011) recommend parent training (PT) for ‘treating’ maladaptive perfectionism in Asian American families. Ironically, in their discussion of PT, they note that this intervention is only proven to be successful in studies with small sample sizes in Hong Kong Chinese families due to a ‘lack of access to reliable child-care, transportation, or work schedules’ causing high dropout rates (Fung, et al., 2011:188).

Somaticization: Worker disablement as a metaphor?

Historically, Western clinicians thought that Chinese neurasthenia was an example of unacknowledged psychological conflict. This belief persists in ongoing studies of Asian American somaticization—one of the original symptoms of neurasthenia in China. In cross-cultural psychology, somaticization refers to the conversion of subjective distress into perceptions of bodily dysfunction, such as lethargy and insomnia. According to Lippincott and Mierzwa (1995:201), '[a] common trait among those students whose cultural background was Asian appeared to be their tendency, when seeking help, to present somatic complaints in place of psychological complaints.' Notably, mental health experts imply that there exists a mind-body dualism and that Asian conceptions of bodily distress necessarily overlook the domain of human experience that registers as Western 'mental health symptoms.'

In a study comparing the clinical presentation of somatic symptoms among Chinese students and Anglo American students, Yang and WonPat Borja (2007:381) argue that somatic symptoms, such as physical weakness, do not imply a conscious denial of affective distress; on the contrary, somatic symptoms are a culturally accepted 'negotiating tactic' for receiving mental health treatment. Here physical symptoms are understood to exist purely in the realm of metaphor. Like the literature on East Asian face loss, Yang and WonPat Borja believe Asian Americans engage in elaborate performances—of social status, of physical illness—in order to conceal 'real' emotional problems. In this case, somaticization is a culturally sanctioned code for receiving psychological help. Yet the authors do not explore how mental health treatment may be inappropriate or inadequate for addressing Asian American 'needs.'

Returning again to the experiences of foreign domestic workers, I argue that the authors' interpretation of 'bodily discomfort' as a code for affective or anxiety disorders delegitimizes experiences of immigrant worker disablement and lack of access to health care. In their profile of undocumented non-citizen caregivers in the United States, Meghani and Eckenwiler (2009) observe that many undocumented women work as caregivers to dependent elderly people, but they lack benefits like health insurance and sick leave. Their situation is especially dire because undocumented health aides experience the highest rates of job-related injury among all occupations (Meghani & Eckenwiler, 2009). Recent research demonstrates that immigrant health deteriorates post-migration in part because refugees do not come forward with health concerns, fearful it may lead to deportation (Newbold, 2009; Hacker, et al., 2012). This suggests Asian immigrants' recourse to mental health services may be a consequence of barriers to primary health care.

History also provides us with clues about the meaning and significance of 'somaticization.' Take for example the story of Huang Zhenyi. At the age of twelve he was accused of writing a political poster against Chariman Mao. He was publicly shamed and sent to work as a peasant, where he was expected to do the work of an adult. Years later he complained about a

‘searing sense of injustice’ associated ‘with a burning sensation in the head, dizziness and exhaustion’ (Kleinman, 1988:129-130). Like other disillusioned Chinese citizens during the late 1950s and early 1960s, Zhenyi used the language of neurasthenia to protest against his unjust suffering at the hands of the state (Shapiro, 2000). Huang’s complaints about physical exhaustion also suggest that the diagnosis stood in for the literal disablement of a child’s body sentenced to hard labor. To recall my earlier discussion of *ashaktapanna* indexing Indian women’s complex labor struggles in Pune, it is worth considering how Asian American ‘somatic complaints’ constitute both coded expressions of dissent and literal expressions of disablement.

Conclusion

In this article, I have illustrated how symptoms of Chinese and Japanese neurasthenia continue to frame contemporary North American understandings of Asian diasporas. In doing so, I argued that in order to fully understand the power relations of cross-cultural psychology, it is necessary to conduct a genealogy of its very terms of reference: perfectionism, face, and somaticization. These terms and ‘cultural traits’ have histories—histories with agents and actors whose political contexts and complex motivations get discarded in the clinical discourse of Asian American mental health. I, too, am one of these actors.

One of my ‘labels’ is neurasthenia, garnered during a period of crisis as an undergraduate student. Years later, I see it in my medical records and I study my social worker’s case notes. Rather than explore the actualities of my experiences in higher education, my doctors, my helpers, racialized my body as the overachieving immigrant archetype and dismissed my struggles in the classroom. Thus, my ‘problems’ were collapsed onto my phenotype, in which neurasthenia became a code for Asian workaholicism. I am decades and an ocean apart from Huang Zhenyi and yet, we are connected by the same diagnosis. His experiences of political violence and disablement are shrouded in the euphemism of *shenjing shuairuo*. As for me, my risk of being placed on academic suspension and early indications of interstitial cystitis - a chronic bladder disease - are eclipsed by the neurasthenic symptoms of perfectionism and somaticization. My objective in this article was to illustrate how psychology offers narratives to placate and even justify experiences of oppression. In my case, culturally competent assessment and diagnosis also led to a misdiagnosis of chronic pain.

I close my discussion by asking, how does diagnostic inclusion govern racialized and immigrant communities? What do therapeutic interventions like Parent Training for maladaptive perfectionism accomplish? Mental health interventions use cultural idioms such as ‘perfectionism’ that pathologize parent and child behaviors, demanding diasporic families to change ‘problem’ behaviors that stem from systemic injustice. This leaves Asian American families responsible for ‘better’ habits—such as nurturing sensitive and affectionate

relationships—that should be addressed at the collective level.

Cross-cultural counselling homogenizes ‘Asians’ through the rubric of broad ethnic behavior traits, at once erasing shared experiences of institutional racism and inter-Asian differences in conditions for migration. Proponents of multicultural competency must consider the differences between patterns in return migration (Young, 2014) and failed applications for family reunification (Sheppard, 2014) as they theorize Asian Canadian or Asian American family ‘alienation.’ Or, perhaps we should do away with these categories entirely and recognize the distinct histories of Chinese, Thai, and Filipino migrant workers (Hussan, 2012).

References

- Beard, G. M. (1880). *A Practical Treatise on Nervous Exhaustion (Neurasthenia): Its Symptoms, Nature, Sequences, Treatment*. London: Lewis.
- Bouveret, L. (1890). *La Neurasthénie (Épuisement Nerveux)*. Paris: Baillière.
- Briggs, L. (2000). The Race of Hysteria: “Overcivilization” and the “Savage” Woman in Late Nineteenth-Century Obstetrics and Gynecology. *American Quarterly*, 52(2), 246-273.
- Cao, Y. P., Zhang, Y. L., et al. (2009). Psychosocial and Immunological Factors in Neurasthenia. *Psychosomatics*, 50(1), 24-29.
- Center for Disease Control and Prevention (2010). Technical Instructions for Physical or Mental Disorders with Associated Harmful Behaviors and Substance-Related Disorders for Civil Surgeons [Online]. Available at: <http://www.cdc.gov/immigrantrefugeehealth/exams/ti/civil/mental-civil-technical-instructions.html> [Accessed: 7 January 2014].
- Chatterjee, S., Mucina, M., et al. (2012). Telling Multiple Stories of “Race” in Canadian Higher Education. In R. J. Gilmour, D. Bhandar, et al (eds.), *“Too Asian?” Racism, privilege, and post-secondary education* (pp. 121-133). Toronto: Between the Lines.
- Chou, R. S. & Feagin, J. R. (2010). *The Myth of the Model Minority: Asian Americans Facing Racism*. Boulder, CO: Paradigm.
- Columbia Electronic Encyclopedia*, 6th edition (2013). New York: Columbia University Press.
- Compston, A. (2013). War-Neurasthenia, Acute and Chronic. *Brain*, 136, 1681-1686.
- Crozier, A. (2009). What Was Tropical About Tropical Neurasthenia? The Utility of the Diagnosis in the Management of British East Africa. *Journal of the History of Medicine and Allied Sciences*, 64(4), 518-548.
- Daidoji, K. (2013). Treating Emotion-Related Disorders in Japanese Traditional Medicine: Language, Patients and Doctors. *Culture, Medicine and Psychiatry*, 37(1), 59-80.
- Drinot, P. (2004). Madness, Neurasthenia, and “Modernity”: Medico-legal and Popular Interpretations of Suicide in Early Twentieth-Century Lima. *Latin American Research*

- Review*, 39(2), 89-113.
- Duster, T. (2005). Enhanced: Race and Reification in Science. *Science*, 307, 1050-1051.
- Foucault, M. (2003). *"Society Must Be Defended": Lectures at the Collège de France 1975-1976*. Translated from French by D. Macey. New York, NY: Picador.
- Fung, J., Ho, L. Y., et al (2011). Directions in Understanding, Preventing, and Treating Disruptions in Parenting and Child Behavior Problems in Asian American families. In F. T. L. Leong, L. Juang, et al (eds.), *Asian American and Pacific Islander Children and Mental Health: Volume 2 Prevention and Treatment* (pp. 175-200). Santa Barbara, CA: Praeger.
- Galarneau, C. (2011). Still Missing: Undocumented Immigrants in Health Care Reform. *Journal of Health Care for the Poor and Underserved*, 22(2), 422-428.
- Gerstein, L. H., Heppner, P. P. et al (2012). Cross-Cultural Counseling: History, Challenges, and Rationale. In L. H. Gerstein, P. P. Heppner et al (eds.), *Essentials of Cross-Cultural Counseling* (pp. 1-45). Los Angeles, CA: SAGE Publications.
- Gorman, R. (2012). Organizer of Transnational Narratives of Disability Speaker Series event *Disability, racism, and work in Canada: Black and Filipina women's experiences of exploitation and resistance*. York University, Toronto, Canada, 25 July 2012.
- Hacker, K., Chu, J., et al (2012). Provider's Perspectives on the Impact of Immigration and Customs Enforcement (ICE) Activity on Immigrant Health. *Journal of Health Care for the Poor and Underserved*, 23(2), 651-655.
- Howell, A. (2011). *Madness in International Relations: Psychology, Security, and the Global Governance of Mental Health*. Abingdon, UK: Routledge.
- Hussan, S. (2012). 'Worker exploitation is not just a Chinese problem,' *Huffington Post* [Online], November 2. Available at: http://www.huffingtonpost.ca/syed-hussan/migrant-worker-exploitation-canada_b_2065974.html [Accessed: 25 June 2014].
- INCITE! (n.d.). *Law Enforcement Violence Against Women of Color & Trans People of Color—A Critical Intersection of Gender Violence & State Violence: An Organizer's Resource and Tool Kit* [Online]. Redmond, WA: INCITE! Women of Color Against Violence. Available at: <http://www.incite-national.org/index.php?s=103> [Accessed: 25 June 2014].
- Kanani, N. (2012). Disabling identities: Considering the role of race gender, and status in accessing health and disability services. Paper presented at the Rebuilding Bridges Conference, York University, Toronto, Canada, 18 November 2012.
- King, R. D., Massoglia, M. et al (2012). Employment and Exile: Criminal Deportations, 1908-2005. *American Journal of Sociology*, 117(6), 1786-1825.
- Kleinman, A. (1988). *Social Origins of Distress and Disease: Depression, Neurasthenia, and Pain in Modern China*. New Haven, CT: Yale University Press.
- Kuriyama, S. (1997). The Thought on Stiff Shoulders. In K. Yamada and S. Kuriyama (eds.). *Illness and Medicine in History* (pp. 37-62). Kyoto: Shibunkaku.
- Lee, S. & Kleinman, A. (2007). Are Somatoform Disorders Changing With Time? The Case

- of Neurasthenia in China. *Psychosomatic Medicine*, 69(9), 846-849.
- Leong, F. T. L., Kim, H. H. W., et al (2011). Attitudes Toward Professional Counseling Among Asian-American College Students: Acculturation, Conceptions of Mental Illness, and Loss of Face. *Asian American Journal of Psychology*, 2(2), 140-153.
- Lin, T. Y. (1989). Neurasthenia Revisited: Its Place in Modern Psychiatry. *Culture, Medicine and Psychiatry*, 13(2), 105-129.
- Lippincott, J. A. and Mierzwa, J. A. (1995). Propensity for Seeking Counseling Services: A Comparison of Asian and American Undergraduates. *Journal of American College Health*, 45(5), 201-204.
- McClintock, A. (1995). *Imperial Leather: Race, Gender and Sexuality in the Colonial Contest*. New York, NY: Routledge.
- Mahmod, S. (2004). *Politics of Piety: The Islamic Revival and the Feminist Subject*. Princeton, NJ: Princeton University Press.
- Meghani, Z. and Eckenwiler, L. (2009). Care for the Caregivers?: Transnational Justice and Undocumented Non-citizen Care Workers. *International Journal of Feminist Approaches to Bioethics*, 2(1), 77-101.
- Metzl, J. M. (2009). *The Protest Psychosis: How Schizophrenia Became a Black Disease*. Boston, MA: Beacon Press.
- Mio, J. S., Nagata, D. K., et al (2007). Racism Against Asian/Pacific Island Americans. In F. T. L. Leong, A. G. Inman, et al (eds.), *Handbook of Asian American Psychology* (2nd ed., pp. 341-362). Thousand Oaks, CA: Sage Publications.
- Mills, C. (2014). *Decolonizing Global Mental Health: The Psychiatrization of the Majority World*. London: Routledge.
- Molina, K. M., Chen, C-N. et al (2012). Prevalence of Neurasthenia, Comorbidity, and Association with Impairment Among a Nationally Representative Sample of US Adults. *Social Psychiatry and Psychiatric Epidemiology*, 47(11), 1733-1744.
- Nessel, L. A. (2012). Disposable Workers: Applying a Human Rights Framework to Analyze Duties Owed to Seriously Injured or Ill Migrants. *Indiana Journal of Global Legal Studies*, 19(1), 61-103.
- Newbold, B. (2009). The Short-term Health of Canada's New Immigrant Arrivals: Evidence From LSIC. *Ethnicity & Health*, 14(3), 315-336.
- Orsat, M., Ernoul, A. et al (2013). La Neurasthénie du XIX^e Siècle au XXI^e Siècle: Figures et Masques de la Première Maladie Psychosomatique/History of the Concept of Neurasthenia and its Modern Variants. *Annales Médico-psychologiques, revue psychiatrique*, 171(6), 357-361.
- Paralikar, V., Agashe, M., et al (2011). Cultural Epidemiology of Neurasthenia Spectrum Disorders in Four General Hospital Outpatient Clinics of Urban Pune, India. *Transcultural Psychiatry*, 48(3), 257-283.
- Parreñas, R. S. (2001). *Servants of Globalization: Women, Migration, and Domestic Work*. Stanford, CA: Stanford University Press.
- Rabinbach, A. (1992). *The Human Motor: Energy, Fatigue, and the Origins of Modernity*.

- Berkeley, CA: University of California Press.
- Ribot, T-A. (1896). *The Diseases of the Will*. Snell. Chicago, IL: Open Court.
- Schuster, D. G. (2011). *Neurasthenic Nation: America's Search for Health, Happiness, and Comfort*. New Brunswick, NJ: Rutgers University Press.
- Shapiro, H. (2000, June). Neurasthenia and the assimilation of nerves into China [Online]. In, Academia Sinica, Institute of History & Philology, *Symposium on the History of Disease*. [Online] Nankang, Taiwan. Available at: <http://www.ihp.sinica.edu.tw/~medicine/conference/disease/shapiro.PDF> [Accessed: 25 June 2014].
- Sheppard, J. (2014). 'Karen Talosig heartbroken over 4-year wait to bring deaf daughter to Canada,' *CBC News* [Online], May 29. Available at: <http://www.cbc.ca/news/canada/british-columbia/karen-talosig-heartbroken-over-4-year-wait-to-bring-deaf-daughter-to-canada-1.2658635> [Accessed: 25 June 2014].
- Showalter, E. (1985). *The Female Malady: Women, Madness, and English Culture, 1830-1980*. London, UK: Virago.
- Slijkhuis, J. & Oosterhuis, H. (2012). 'Paralyzed with Fears and Worries': Neurasthenia as a Gender-Specific Disease of Civilization. *History of Psychiatry*, 24(1), 79-93.
- Smith, D. E. (1983). No One Commits Suicide: Textual Analysis of Ideological Practices. *Human Studies*, 6(4), 309-359.
- Stevenson, A. & Lindberg, C. A. (eds.) (2010). *New Oxford American Dictionary*, 3rd edition. Oxford: Oxford University Press.
- Sue, D. W. and Sue, D. (2003). Counseling Asian Americans. In *Counseling the Culturally Diverse: Theory and Practice* (pp. 327-342). New York, NY: Wiley.
- Sue, S., Zane, N., et al (1994). Research on Psychotherapy with Culturally Diverse Populations. In A. E. Bergin and S. L. Garfield (eds.), *Handbook of Psychotherapy and Behavior Change* (4th ed.) (pp. 783-817). New York, NY: Wiley.
- Suzuki, B. H. (2002). Revisiting the Model Minority Stereotypes: Implications for Student Affairs Practice and Higher Education. In M. K. McEwen, C. M. Kodama, A. N. Alvarez, S. Lee, and C. T. H. Liang (Eds.), *Working with Asian American College Students* (pp. 21-32). San Francisco, CA: Jossey-Bass.
- Svoboda, H. (2011). Enforcement is Next Task for Law on Wage Theft. *New York Times* [Online], October 29. Available at: http://www.nytimes.com/2011/10/30/us/organizations-work-to-enforce-wage-theft-bill-aimed-at-immigrants-employers.html?_r=0 [Accessed: 25 June 2013].
- Swartz, L. (2012). An Unruly Coming of Age: The Benefits of Discomfort for Global Mental Health. *Transcultural Psychiatry*, 49(3-4), 531-538.
- Taylor, R. E. (2001). Death of Neurasthenia and its Psychological Reincarnation: A Study of Neurasthenia at the National Hospital for the Relief and Cure of the Paralyzed and Epileptic, Queens Square, London, 1870-1932. *British Journal of Psychiatry*, 179, 550-557.
- Troyna, B. and Siraj-Blatchford, I. (1993). Providing Support or Denying Access? The

- Experiences of Students Designated as 'ESL' and 'SN' in a Multi-ethnic Secondary School. *Educational Review*, 45(1), 3-11.
- Üstün, B. & Kennedy, C. (2009). What is 'Functional Impairment'? Disentangling Disability from Clinical Significance. *World Psychiatry*, 8(2), 82-85.
- Yang, L. H. and WonPat-Borja, A. J. (2007). Psychology Among Asian Americans. In F. T. L. Leong, A. G. Inman, et al (eds.), *Handbook of Asian American Psychology* (2nd ed.) (pp.379-405). Thousand Oaks, CA: Sage Publications.
- Yeh, C. J., Borrero, N. E., et al (2011). Stress and Coping Among Asian American Pacific Islander and Native Hawaiian Children and Youth: An Asset Approach. In F. T. L. Leong, L. Juang, et al (eds.), *Asian American and Pacific Islander Children and Mental Health: Volume 2 Prevention and Treatment* (pp. 101-124). Santa Barbara, CA: Praeger.
- Yew Schwartz, P. (2002). Why is Neurasthenia Important in Asian Cultures? *Western Journal of Medicine*, 176(4), 257-258.
- Young, I. (2014). 'Home is where the glowing heart is: Why you feel more Canadian when you live in Hong Kong,' *South China Morning Post* [Online], June 25. Available at: <http://www.scmp.com/comment/blogs/article/1540044/home-where-glowing-heart-why-you-feel-more-canadian-when-you-live-hk> [Accessed: 25 June 2014].
- Zane, N. & Yeh, M. (2002). The Use of Culturally-based Variables in Assessment: Studies on Loss of Face. In K. S. Kurasaki, S. Okazaki, et al (eds.), *Asian American Mental Health: Assessment Theories and Methods* (pp. 123-139). New York, NY: Kluwer Academic/Plenum Publishers.