

Cultural Considerations in using Cognitive Behaviour Therapy with Chinese People: A Case Study of an Elderly Chinese Woman with Generalised Anxiety Disorder

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The under-utilisation of mental health services amongst Chinese people is a well-known fact. This article describes a case study using a Western therapy model, cognitive-behavioural therapy (CBT), with a Chinese client. A CBT model, modified for working with Chinese clients, is depicted with reference to Chinese practices and behaviours, and this is then applied to a case study with an elderly Chinese woman. CBT was shown to be useful with this Chinese client. Challenges to the use of CBT with Chinese people are discussed with implications for clinicians working in this area.

It is frequently noted that very few Chinese people, here and overseas, utilise mental health services and even less will self-refer (Ho, Au, Bedford, & Cooper, 2003; Netto, Gaag, Thanki, Bondi, & Munro, 2001). If help is sought, it is often when a crisis occurs and, if treatment is initiated, terminated prematurely. The factors associated with low utilisation and high dropout rates in mental health facilities have long been recognised (e.g., Ho et al., 2003; Williams & Cleland, 2006; Williams, Graham, & Foo, 2004; Yip, 2005). Traditional Asian beliefs liken mental illness with insanity and, as such, there is much stigmatisation attached to having such problems and seeing a mental health practitioner. It is not surprising, therefore, that this not only leads to denial of the existence of a problem but also creates barriers to help-seeking.

The low rate of attendance at mental health facilities may lead to erroneous assumptions that Chinese people do not experience mental health problems. A literature review by Ho and associates (2003), in fact, revealed that the prevalence rate for mental illness

of Asian people in New Zealand was no different from that of European New Zealanders. Recent migrants experienced even higher levels of mental health problems, presenting with high levels of post-traumatic stress symptoms, clinically diagnosable depressive symptoms, and greater levels of anxiety and emotional distress. Many of these psychological symptoms could be attributed to immigration and the process of adjustment into a foreign culture (Ho et al., 2003; Mak, Young, Wong, & Zane, 2005).

Despite the growing literature on cross-cultural counselling and the ethical concerns surrounding competency and training of psychotherapists working with multicultural clients (Pedersen, 2003), little attention has been given to the therapeutic framework that could be used for counselling Chinese people (for exceptions refer Harper & Stone, 2003; Higginbotham & Tanaka-Matsumi, 1981; Hong & Domokos-Youngg Ham, 2001; Tanaka-Matsumi, Seiden, & Lam, 1996). Due to the stigma and shame surrounding mental illness there is often reluctance to seek help for mental health problems. External explanations,

whether it originates from organic or moral/spiritual sources, has far greater acceptance than psychological explanations, and thus psychological distress is commonly manifested in somatic symptoms for Asian people. Consultations with medical practitioners or traditional Chinese healers for somatic complaints often legitimises help-seeking for problems which may have psychological origins. A therapeutic framework that was compatible with the expectations of Chinese people may encourage utilisation of mental health services and in improving treatment outcomes.

It is frequently noted that Chinese people favour treatment that is directive, structured, and short-term (Young & Davenport, 2005), as this conforms to the expectations of professionals as authoritative experts. It was found that this style was more effective in treatment outcome with Chinese people than with a non-directive person-centred approach (Chu, 1999). Cognitive-behavioural therapy (CBT) is an evidence-based, explicit, structured, and problem-focused short-term psychotherapy. The principles and practice of cognitive-behavioural therapy (CBT) would appear to be compatible with the expectations favoured by Chinese people as it promotes self-help and is psycho-educational; teaching new coping skills to manage distressing emotional problems. Its conceptual framework is also well-placed to take into account the idiographic nature of the client's problems in relation to cultural factors

and the impact of immigration, somatic complaints, interpersonal relationships, and other areas of importance that impinge on the client's psychological well-being.

It would be expected that this match in the expectations of treatment would not only increase the appeal of CBT for Chinese people but also of mental health services. For example, Zane, Sue, Chang, Huang, Huang, Lowe, et al. (2005) found that even when the therapist and client were not ethnically matched, significant therapeutic achievements were found if the therapist and client shared similar perceptions of the presenting problem, client's coping style, and expectations about treatment goals. This therapist-client "cognitive match" was significantly related to positive attitudes towards the therapy sessions, a reduction in avoidant coping

behaviours, and an improvement in psychosocial functioning.

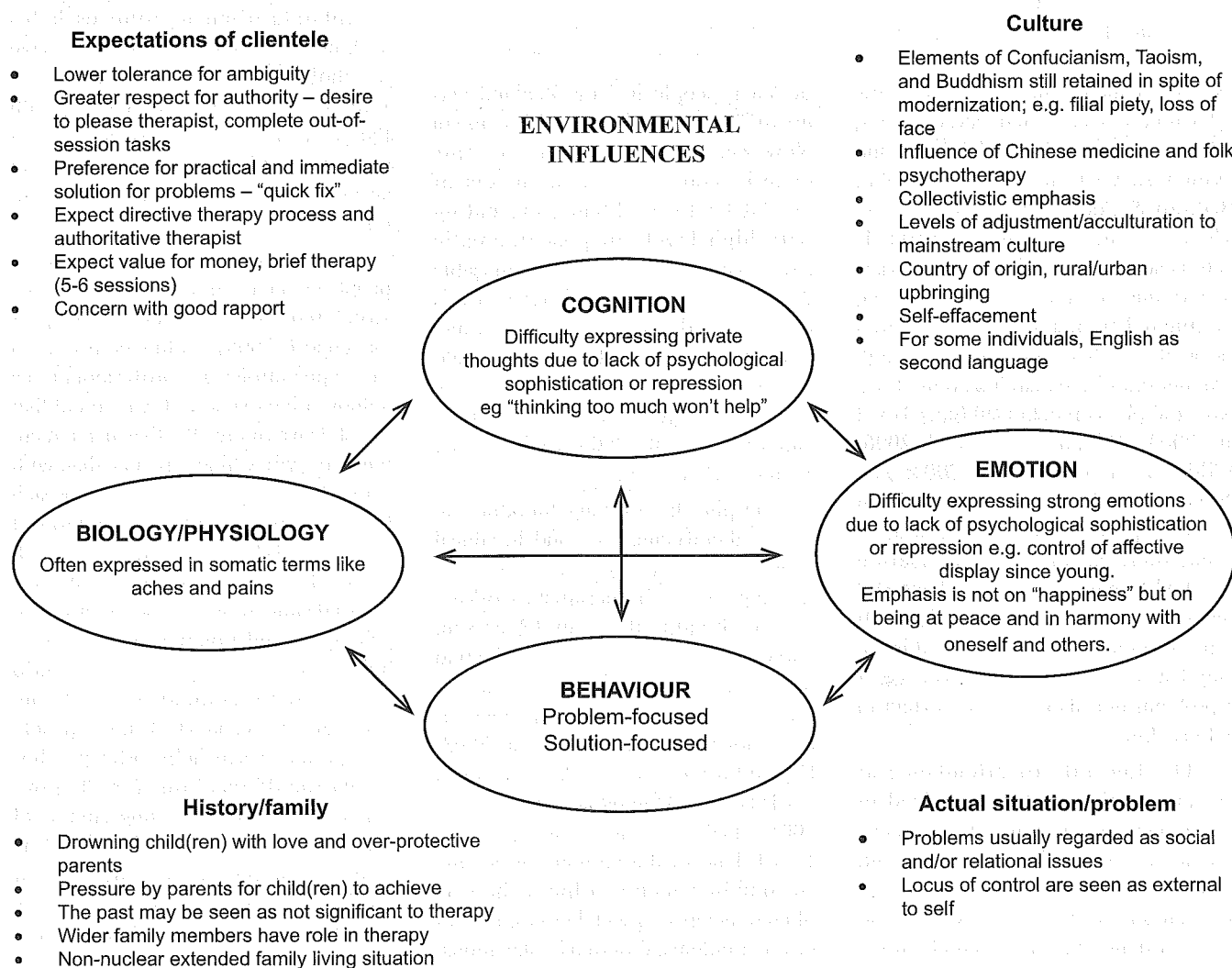
It is therefore proposed that CBT could be used as a conceptual framework in which to help the client develop an understanding of his/her problem and this then used for treating Chinese people with mental health concerns. The remaining paper will, firstly, present an outline of the CBT model for working with Chinese people, and secondly, a case study in which to illustrate the application of CBT with an elderly Chinese woman with generalised anxiety disorder.

Using the 5-part CBT model for working with Chinese people

Padesky and Mooney (Padesky & Mooney, 1990) developed the Five-Part Cognitive Model that represents the relationship between emotion, thought,

behaviour, and physical reactions, and that these, in turn, have been influenced by one's environmental factors, such as genetics, culture, history, and the actual problem situation (see Figure 1). The bi-directional arrows indicate the dynamic interconnections between the various parts of the system, indicating that change in one area will create change in the other areas as well. This 5-part model provides a useful framework in which to conceptualise the idiosyncratic nature of a client's presenting difficulties, establish a therapeutic alliance, and to guide treatment. In keeping with the structure of Padesky and Mooney's model, each part of the model will be discussed further below taking into consideration the cultural characteristics of Chinese people. Some parts of the model will have greater prominence for the Chinese client than others (refer Figure 1).

Figure 1: Cognitive behavioural therapy model for working with Chinese clients



Environmental Influences

Expectations of the Chinese client:

Chinese people regard professionals as authority figures, knowledgeable, and to be respected. Thus it would be preferable to adopt an instructive and didactic style early in the therapeutic relationship, with less emphasis on collaborative empiricism and guided discovery in the initial stage of therapy. Once rapport has been firmly established then guided discovery and collaborative empiricism can be used. This will increase confidence and trust in the therapist's ability to help and develop a therapeutic alliance. A facilitative client-focused approach to counselling does not conform to the image of a traditional cultural healer and taking this approach may negatively impact on the engagement of the Chinese client into a therapeutic relationship. Chinese people also believe in value for money so some symptom relief needs to be achieved early in treatment and therapy sessions should be short-term; lasting no more than five to six sessions. However, the eagerness to get well and comply with the therapist's requests will make the Chinese person an ideal client in completing out-of-session tasks.

Culture: The influences of Confucianism, Taoism, and Buddhism remain strong despite Westernisation and acculturation. They influence how mental health is perceived and the cause of the problem. They teach the virtues of moderation and proper conduct, and for the restraint of strong emotional affect and excessive behaviours, the avoidance of interpersonal conflict, and the suppression of self-expression (Yip, 2005). In fact, strong emotions and interpersonal conflict are seen as the cause of distress and mental health problems. Maintaining harmonious social interactions are paramount and it is through self-control and self-discipline that tranquillity of the mind, fulfilment, and peace are attained. Traditional Chinese medicines are frequently used as an adjunct to other forms of therapy as physical and mental illnesses are not considered separate entities but are holistically interconnected to mental health and well-being.

Related to culture is the need to

understand the level of acculturation of the Chinese client. Although the majority of Chinese people have been in New Zealand for less than 10 years, many are from several generations of New Zealand-born Chinese and therefore the issues they face will be dissimilar to those of the recent migrants. It has been shown that cultural identity is related to psychological health and help-seeking behaviour (refer Kim, Atkinson, & Umemoto, 2001).

History/Family: The strength of the Chinese family structure is in providing an environment for mutual support and interdependence (Cheung, 1986). For non-Chinese people, the close extended family unit may appear to be overly enmeshed and controlling, especially over its younger members. For example, the Chinese parents may seem to over-indulge their children, almost to the point of "drowning them with love", be closely involved in every aspect of the child's life, and make decisions for them, often without consultation, into late adolescence. Individual family members generally have a strong sense of responsibility and obligation to the family, with great importance attached to academic and occupational achievement. Pressure on children to succeed may appear excessive to non-Chinese people.

The traditional Chinese family system is patriarchal with deference given to those in higher authority. Roles are strongly defined for each member within the family structure, and suppression of individual rights, desires, wants, or needs to the greater goals of the family are expected (Yip, 2005). The primacy of the family and its influence on the individual family member's behaviour can be difficult for non-Asians to comprehend (Curren, 1997).

Situation/Problem: Under the influence of traditional Chinese culture, which values reliance on the social collective over individual autonomy, Chinese clients are more prone to perceiving the problem as being an external locus of control than an internal locus of control. Thus problems will generally be presented as of social or relational origin, rather than individually-oriented. When confronted by oppressive and or

challenging social situation, the Chinese client may exhibit passive-helpless and egocentric behaviours, with solutions expected from "authority" figures to resolve the difficulty (Yip, 2005).

Biology, Cognitions, Behaviour, and Emotion

The emphasis on emotional restraint, moderation and control of one's feelings and emotions will make disclosure and sharing one's inner feelings uncomfortable for a Chinese person. Disclosing private feelings can feel strange and there is generally a reluctance to discuss personal details with someone perceived as a "stranger", even a professional. Talking about somatic complaints or issues of a more practical nature, such as financial or academic problems, is usually easier than expressing mental health symptoms.

These present potential problems as identification of emotions are central to CBT. To overcome these barriers, instead of expecting the client to verbalise and express feelings, it may be more useful to focus on the somatic symptoms and use problem-solving strategies early in therapy. As emotional and cognitive reactions may not be spontaneously expressed, direct enquiry into psychological symptoms can be applied. Organic symptoms relabelled or reframed into psychological terminology may become more acceptable as rapport and trust develops. This is more likely to engender rapport building and enhance the Chinese client's faith that psychological therapy is beneficial and effective.

Research into the effectiveness of the cognitive behavioural therapy model with Chinese people is limited (an exception see Chen & Davenport, 2005) and for this reason a single case study design is presented to evaluate its potential to work with Chinese people with mental health concerns.

Case Study

"Mrs. Young" (a pseudonym)¹ was referred by an Asian support group in a public hospital. She was an outpatient of the mental health facility for older people at the hospital, and had been diagnosed and treated for

depression and generalised anxiety symptoms for the past few months by her psychiatrist. She was a 69 year old Chinese woman who had lived in New Zealand for over 20 years and was fluent in both Cantonese and English. English was used as the medium for communication. Treatment had been carried out in an interdisciplinary team that included psychiatrists, social worker, psychiatric nurses, and the manager of the Asian support group and was primarily psychopharmacological. The referral for psychotherapy was largely precipitated by the inexplicable nature of Mrs Young's problems. These seemed rather indeterminate, with ongoing complaints of health problems and cognitive difficulties and little amelioration of the symptoms despite the medication. Baffled by the lack of progress, Mrs Young was referred to one of the authors (FKH, a Singaporean-Chinese) for CBT. No psychotherapy had been carried out prior to this referral.

History

Mrs Young's problems with depression and anxiety coincided with her husband being hospitalized long-term and being left on her own. She met her husband, a New Zealander, whilst attending an English language course in New Zealand, and they have been married for over 20 years. No children were produced from this relationship. Mrs Young reported the first 10 years of the marriage was happy and uneventful but when her husband was diagnosed with diabetes, she stated that had she known of his illness she would not have married him². More recently, the deterioration in her husband's condition required several operations so that he eventually became incapacitated and was placed into long term care as Mrs Young was unable to look after him at home.

In her family of origin, Mrs Young was raised in a close-knit Chinese family unit, being the youngest of three children. She described being spoilt and over-protected by her parents and that most decisions were made for her. Schooling and friendships were normal and, upon leaving school, she trained to be a nun. She left this vocation after some years, coming to New Zealand

to attend an English course where she met her future husband. After her marriage, Mrs Young worked as a language teacher.

Assessment

Clinical interview: The assessment and initial therapy sessions were conducted in Mrs Young's home as she complained of poor vision and felt unsafe driving on her own to the clinical sessions. It was later deduced that she was capable of driving to her other social activities without complications, and that she was also having the social worker and the psychiatric nurse visit her at home every week. It was decided the remaining therapy sessions be arranged at the hospital or clinic in order to preserve the integrity of the therapeutic boundaries, especially after one session at her home when she asked the therapist to help with chores around the home. Mrs Young presented as frail, considerably underweight, almost to the extent of being emaciated, and dysphoric. She was neatly dressed and spoke in a calm soft voice. Although doubtful about the benefits of psychotherapy, it was agreed she would be seen initially for six sessions. Despite her reservations about being seen for psychotherapy, Mrs Young was compliant and readily volunteered a litany of problems that troubled her, rapidly fluctuating from one problem to the other; to the extent of being repetitious and unrelenting.

The symptoms centred on low energy, diminished concentration, restlessness, sleep disturbance, considerable weight loss, and inability to make decisions. In addition, anxiety symptoms were experienced, such as trembling and palpitations, short panic spells which occurred mainly upon morning awakenings, and feeling fearful when alone. She reported continually worrying about her health and her forgetfulness. When engaged in social activities, these anxiety symptoms diminished. She was particularly reliant on her church and friends for social interactions but had noticed that people were avoiding her and would not engage in conversation for any length of time. When probed on subjects she did not wish to talk about, she rapidly changed the topic

of conversation, thus avoiding further analysis of the issue. No evidence of suicidal ideation or suicidal behaviour was found.

Mrs Young identified her main problems as her financial difficulties, trouble taking the medication, sleeping only about two hours each night, and the inability to make decisions. She expressed thoughts about "It's my fault for taking life so easy", and "I'm disappointed in myself (for not managing)". Since her husband's hospitalization, she had to rely on her diminishing financial resource. In order to manage on her reduced financial state, she decreased her food intake to save money.

Medication

Mrs Young was prescribed Nortriptyline, Imovane, and Loazepam for her anxiety, depression and sleeping problems. They did not appear to improve her symptoms and it was later disclosed that she had not kept to the medication regime. Mrs Young had consulted the internet and after finding out about the side-effects and contraindications of these medications, she considered they were harmful with long term use and thereafter only took the anxiolytic when she felt anxious and the anti-depressant sporadically. Traditional Chinese medicines were taken at times in conjunction with the psychopharmacology.

Psychometric measures

In addition to the clinical interview, the following psychometric measures were completed to evaluate therapy progress:

Beck Depression Inventory (BDI: Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), a self-rating scale of attitudes and symptoms associated with depression. Mrs Young's score was in the severe range for depressive symptoms. Highest scores were given for "I blame myself for everything bad that happens", "I can't make decisions at all anymore", and problems with weight loss, waking up several hours earlier, and fears of making decisions about everyday things.

State-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, & Lushene, 1970): A self-rating scale that measures

state and trait anxiety. Mrs Young's score was in the range for an anxious population group.

Automatic Thoughts Questionnaire (ATQ: Hollon & Kendall, 1980): A self-rating measure of recent spontaneous negative automatic thoughts or negative self-statements, in which Mrs Young's score was in the depressed group range.

Dysfunctional Attitude Scale (DAS: Weissman & Beck, 1978): This self-report is used to measure core assumptions underlying depressogenic beliefs and attitudes. Mrs Young's total score was within the normal range although she endorsed a number of items that reflected her need to receive approval from others in order to feel worthy and happy.

On the Suitability for Short-term Cognitive Therapy scale (Safran & Segal, 1990; 1993), the areas that were identified for Mrs Young as being amenable to cognitive therapy were her ability to access her automatic thoughts, her willingness to carry out out-of-session tasks, the development of rapport with the therapist, evidence of good interpersonal functioning despite her current difficulties, low level of chronicity in the problems, and generally being open to discussing her difficulties although there was avoidance of specific anxiety-provoking situations. Problematic areas, however, were her lack of differentiation between her emotional states, the expectation that the therapist would provide the "magic solution", her lack of focus on task-specific activities without prompting, and her expression of scepticism about the benefits of therapy.

Case Conceptualisation

Cultural Considerations: In order to understand the idiographic nature of Mrs Young's current difficulties, it is important that her cultural background are taken into consideration when making a formulation of this client's problems, thus placing it within the context of her culture, gender, and age.

Some Asian countries are exposed to more Westernised influence than others (eg Malaysia, Hong Kong, and Singapore) but many Chinese from these countries still retain their

traditional cultural beliefs and practices, even if they have lived for many years outside their country or have married a non-Chinese. Mrs Young has lived in New Zealand for over 20 years, but despite this much of her presentation is influenced by her early cultural upbringing. Her age would predict she would hold more traditional Chinese cultural beliefs and values than a younger person of Chinese descent who would generally integrate into the New Zealand culture more easily. Thus many of the considerations for working with a Chinese client are essential when understanding the nature of Mrs Young's difficulties.

First, Mrs Young is from an older generation to the therapist working with her. Due to the deference given to people from an older generation, it is not expected that young people will question or give advice to an older person. This is reflected in a Chinese proverb "I have taken more salt than you have taken rice", which means "I have more life experiences than you and therefore you can't teach me anything". A similar New Zealand axiom would be "Don't teach your grandmother to suck eggs". Receiving therapy from someone younger and eliciting personal information could be regarded as great disrespect and "loss of face" for an older Chinese person. Threats to the therapeutic alliance may be manifested by extreme politeness and formality, telling you what s/he thinks you wish to hear, and avoidance of disclosing personal details. In this particular situation, the therapist had completed post-graduate training in the application of CBT and therefore perceived as an expert in this area, which would help counteract the negativity of working with a young person. In addition, the therapist was of similar ethnic match to the client (unlike the members of the interdisciplinary team) and this may have increased a willingness to try a novel treatment approach. Ethnic matching of client-therapist variables is often seen as a component in cross-cultural therapy that enhances the therapeutic outcome (Zane et al., 2005).

Second, as is typical in many traditional Chinese families, Mrs Young was raised in a close family

unit where she was overprotected and cosseted by her family members and it would be expected her family would make important decisions for her. Being a female with relatively low social status, Mrs Young would be seen as "marrying up" through her marriage to someone from a Western country, thus improving her social status. This would be further enhanced by moving to a country seen as superior where there were greater opportunities for a better life. There are pressures therefore to make this new life succeed, as failure would be seen as a "loss of face" and bring shame to her family and friends. In her marriage, Mrs Young's early modelling of dependency on her parents would be transferred to her husband as it is expected that a Chinese wife would rely very much on her husband for decision-making and that he would provide for her.

Third, children, especially sons, are important sources of support for aging parents and are relied upon for financial and emotional support when the parents are no longer able to take care of themselves. As such, children are greatly valued in Chinese families and not having a child to take care of one in one's old age is an enigma and socially stigmatizing. In studies of elderly Chinese living on their own, it was found that those who had children to whom they could rely upon for support had greater levels of life satisfaction than those who had no family support (Lam & Boey, 2005; Lee, 2005). With her husband being incapacitated, Mrs Young had no close family member to whom she could turn to for support and to take over the carer role performed by her husband. To some extent, Mrs Young's request to the therapist to do errands for her was transferring her expectations onto the therapist as she would a surrogate "son". It is most probable that had Mrs Young had children she would have relied on them instead and would not have presented in the mental health system. It is typical, however, that Chinese clients will request help from the therapist in areas that would be regarded to be outside the therapeutic relationship, such as inviting them to family social activities, help for other extended family members, intervening with other agencies, and a range of

different problems. Thus maintaining the therapeutic boundary can be an important issue in treating Chinese clients.

Finally, Mrs Young was able to legitimise seeking help from the mental health service by focusing on the physical aspects of her symptoms and on more general vague health-related complaints, such as tiredness and memory/concentration problems. These symptoms elicited help for problems that she saw primarily as financial rather than her helplessness and inability of cope and manage on her own. Her frailty, passivity, and helplessness elicited considerable amount of concern and assistance from the mental health team and her friends. However, her expectation was that the mental health team would resolve her problems rather than actively participate in her own recovery.

Problem formulation: Mrs Young experienced problems with symptoms of depression and anxiety, including poor sleep and concentration, negative thinking mainly concerning guilt about not being able to cope, weight loss, indecisiveness, and generalised worries, which was precipitated by her husband's hospitalisation. Predisposing factors included an over-dependency on her husband and other authority figures, an extremely sheltered marital relationship, and not much experience in taking responsibility for others or independent decision-making. Maintaining factors were her core beliefs around vulnerability and helplessness resulting in compensatory strategies, such as frequent reassurance-seeking and avoidance of situations requiring independent decision making. Protective factors included her sociability and this being her first presentation to the mental health service. A diagnostic impression gained was that Mrs Young was suffering from features of depression and generalised anxiety disorder against the background of adjusting to her changed circumstances caused by her husband's hospitalisation and being on her own.

A diagrammatic cognitive-behavioural formulation is given for Mrs. Young in Figure 2 (Morrison, 2000). There are aspects of Mrs Young presentation that are indicative of a

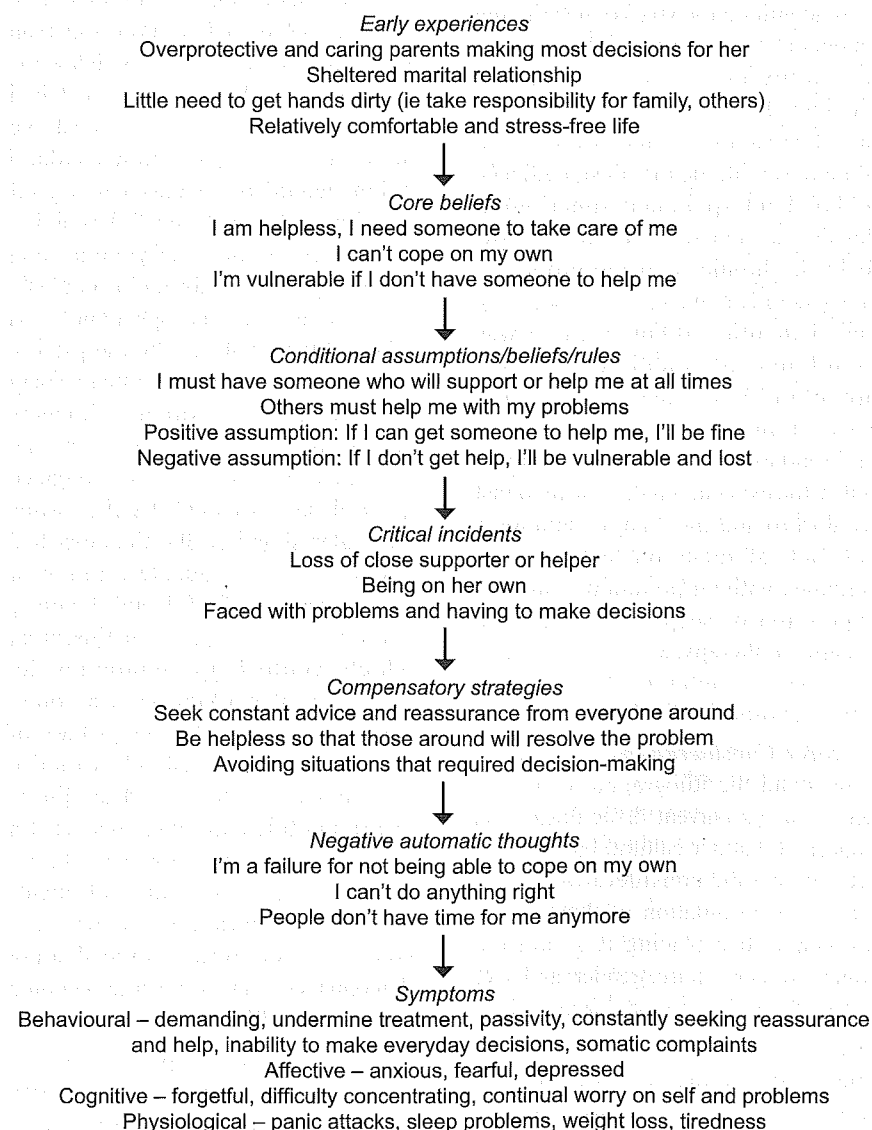
dependent personality, that includes difficulty in making every day decisions, excessive reliance on others to obtain nurturance and support, exaggerated feelings of helplessness, and inability to take care of herself. To diagnose her with a personality disorder, however, would be unjustified as her presentation is relatively common given her cultural background, her age, and her situation. Furthermore, there was no evidence of psychopathology prior to her current difficulties.

Treatment

The goals of therapy were to obtain symptom-relief from depression and anxiety for Mrs Young and to familiarise her to the five-part model so as to help

her conceptualise the nature of her problems. Initially Mrs Young agreed to six to seven sessions of CBT, and as therapy progressed she extended this to thirteen sessions. As was typical with Chinese clients, Mrs Young expected therapy to be short-term and that she would "get well" quickly. Early treatment strategy was to orient Mrs Young to cognitive behavioural therapy using the Padesky and Mooney's (1990) 5-part model. She quickly understood the inter-relationship between affect, cognitions, physiological arousals, and behaviour. To monitor treatment progress, the visual analogue scale (VAS; see Figure 3) was introduced, with "0" being "Not anxious at all" to "100" being "Most anxious". Self-

Figure 2: Cognitive-behavioural formulation for Mrs Young



rating on anxiety levels were obtained at each session. As the client seemed able to articulate her thoughts clearly, the thought record was presented in the fifth session in order to identify her negative automatic thoughts and to challenge her beliefs. The activity evoked strong emotions in Mrs Young, to the extent that she became agitated and avoidant in using the thought record. It was decided that intervention would focus primarily on the behavioural-based components of cognitive behavioural therapy.

Activity rescheduling: Activity rescheduling is a commonly used technique in cognitive therapy and served several functions. Mrs Young complained of boredom and having too much time in which to worry, and thus the schedule was used to identify the times in the day when she became more anxious or depressed and her level of activity. This showed Mrs Young to be most anxious in the morning and when she would most likely use the anxiolytic medication. The period of time when she was on her own or doing activities by herself (such as gardening) were those she rated as being the most anxious, but when engaged in social activities her anxiety levels reduced to zero.

By being aware of those periods when anxiety was at its greatest, Mrs Young was able to schedule in pleasurable activities which she could engage in on her own, such as listening to music, knitting, watching television, or phoning a friend. Relaxation training was also given to manage the anxiety symptoms. It was noted that by talking about her anxiety periods it heightened her attention and tendency to ruminate on the problem and thus, later in therapy, emphasis was placed on the pleasurable activities in her schedule. A level of rigidity in Mrs Young's daily/weekly schedule was also observed, in that she would be inflexible to altering activities to different days or time.

Interpersonal relationship skills: Mrs Young had some awareness that her dependency on her friends and habitual complaints about her problems were starting to have a negative effect on them, so that they started to avoid her, not visit or phone her, and limiting their time in her company. Her egocentric focus on her problems clouded her ability to consider the implications of

this, and as her friends were her main source of support and socialising with them improved her symptoms, it was important that her interpersonal style be addressed. It was not only with her friends that she lacked this insight but also the effects of the illness and hospitalisation on her husband. Her dependency on him and egocentric focus on her concerns meant she found visiting him a duty that was unenjoyable and distressing.

To address these difficulties, guided discovery and role-plays were practised in the session to help Mrs Young gain an awareness of other people's perspective and their reactions to her. For example, by taking the role of her friends she gained an appreciation of the adverse effect her incessant focus on her problems had for them and to change the conversation to one of mutual interest. A behavioural experiment was designed in which she was to talk to her friends about other matters other than her problems. She reported being positively reinforced for this as she noticed they were more friendly and warm, and spent a longer time talking with her. To help Mrs Young become aware of her automatic response to talk about her problems, Mrs Young's attention would be drawn to this whenever she did this during therapy, and she would be refocused to looking at her goals for therapy. All members of the interdisciplinary team were instructed to do the same, thereby increasing the productiveness of the therapy sessions.

Similar role reversal techniques were applied to her relationship with her husband. Mrs Young blamed him for her predicament, although not overtly, but felt guilty about not being able to take care of him at home. By doing the role-reversal, she gained a greater appreciation of his perspective, being able to accept some responsibility but also accepting that she could not care for him at home. This reduced her negative reactions to his illness and her guilt so that visiting him became a more enjoyable experience.

Psycho-education: Several sources of information were given to Mrs Young to help her understand the nature of her problems. These were information about the development of generalised anxiety disorders taken from Wells (1997) which

specifically focused on her excessive and seemingly uncontrollable worrying, and readings on depression from Mind over Mood (Greenberger & Padeskey, 1995). Mrs Young also spontaneously bought a self-help book on anxiety near the termination of therapy.

Controlled Worry Period: Based on Well's (1997) recommendation for treating "worries" a controlled worry period was introduced. With this technique clients are instructed to schedule 15-30 minutes of their day and devote this time solely to worrying, rather than ruminate throughout the day. This fixed worry period was allocated to when Mrs Young was instructed to worry as much as she wanted. Should worries occur at other times, she was to put that aside until her controlled worrying time. Mrs Young found the exercise amusing but carried out the homework assignment and found that the amount of time she thought about her problems decreased considerably from throughout the day to only once after dinner for a few minutes. As a result, she noticed an increase in her concentration, getting more work done in the day, and learnt she could control her worries. Furthermore, she could see that worrying did not solve her problems but only increased her panic symptoms.

Relaxation techniques: Due to Mrs Young's anxiety and panic reactions, diaphragmatic breathing exercise was firstly taught to help control her breathing and as a relaxation exercise. It took several sessions before she could slow down her breathing and helped her become aware that her shallow and rapid breathing were contributing to her panicky state. On one occasion when Mrs Young became highly agitated and panicky after talking about her husband's illness and her problems, refocusing technique was applied, in addition to the diaphragmatic breathing exercise. The refocusing technique made Mrs Young attend to her immediate environment using different sensory organs, and grounded her and helped her remain calm. Once she had control of her breathing, progressive muscle relaxation was taught to help with sleep and relaxation.

Sleep problems: Stimulus control of Mrs Young's sleeping environment and

sleep hygiene were discussed but she was reluctant to change any of her sleep habits. For example, she slept in a bed that was kept at a high temperature so that she would awake feeling overheated and sweating. When this was discussed, she refused to turn the heat down as she did not wish to change the bed temperature. Furthermore, despite claims of sleeping only two hours a night, Mrs Young did not appear tired during the day, was able to participate in her busy social schedule, function well with day to day activities, and there was no evidence that she napped during the day. She was also reported to sleep soundly during the night by her boarder.

Problem solving techniques: In addition to the financial help Mrs Young was receiving from other sources, problem-solving strategies were used to help her be solution-focused rather than problem-focused. As a result of this Mrs Young took on a boarder, with the intention that this would provide company for her and contribute to the cost of living. When the boarder did not contribute to this, assertive communication was practised and rehearsed during the therapy session. However, in the eventuality Mrs Young decided not to carry this out.

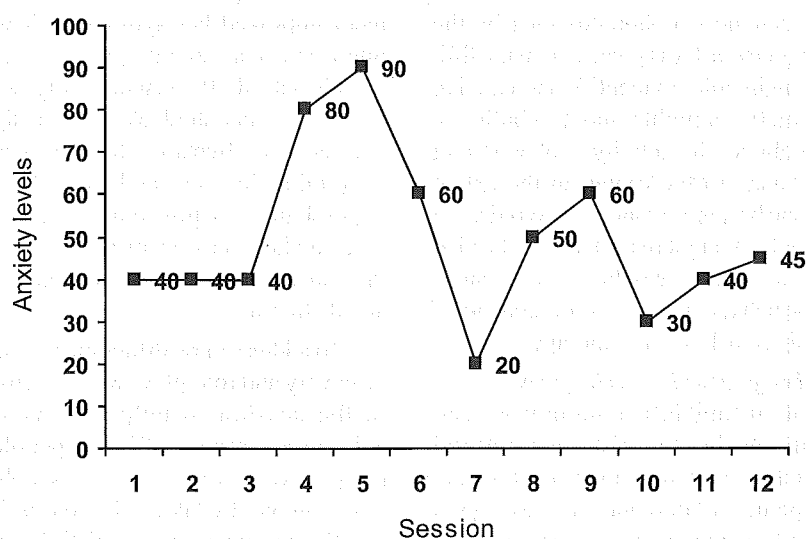
Medication compliance: Interdisciplinary discussion with Mrs Young was held about her non-compliance with medication, but she remained opposed to making changes to her ad hoc use of traditional Chinese medicine and psychopharmacology.

Outcome

The weekly VAS scores (see Figure 3) showed considerable fluctuations with significant increases during the first half of the sessions but decreasing sharply and eventually levelling out to pre-treatment levels.

Psychometric measures taken pre-treatment were re-administered at the end of therapy (see Figure 4). Although the results were not remarkable, they showed Mrs Young moved from being severely depressed to being moderately depressed, with improvements in problems related to sleep,

Figure 3. Session-by-session self-rated anxiety levels

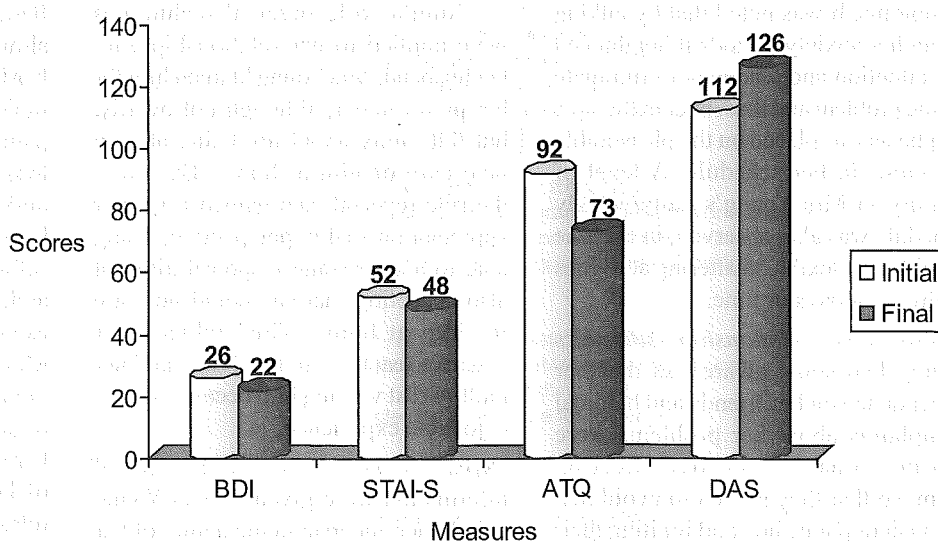


decision making; and a reduction in state anxiety, especially in not feeling as upset, worrying less about possible misfortunes, and feeling more content. Although retaining a number of negative automatic thoughts, the severity of these thoughts were below those associated for depression. A number of dysfunctional attitudes remained although there was a reduction in her need for approval from others.

Discussion and Conclusion

The results of this study showed that a cognitive-behavioural (CBT) framework can be effective in conceptualising the client's problem and in conducting therapy with an elderly Chinese woman, albeit in a limited way. Despite the common perception that Chinese people may not benefit from Western forms of psychotherapy, CBT was partially successful in assisting the client to

Figure 4. Psychometric measures pre- and post-treatment for Mrs Young



Note: BDI = Beck Depression Inventory, STAI-S = State-Trait Anxiety Inventory (State version), ATQ = Automatic Thought Questionnaire, DAS = Dysfunctional Attitude Scale

understand the nature of her problem and guiding treatment to ameliorate some of her anxiety and depressive symptoms. She gained a sense of self-efficacy in being able to control her "worries", take another's perspective which helped to improve her interpersonal relationships, and successfully applied problem-solving strategies. Moreover, the client remained in therapy for a longer period than expected despite her initial reluctance to be exposed to a novel treatment approach. In a study by Lin (1994) the median duration of therapy for Chinese mental health patients was eight sessions even when the therapist was matched on ethnicity and language. In this case, the client attended 13 therapy sessions and the reason for terminating treatment was that the therapist was leaving the service. The interventions used in treatment were mostly behavioural, however, as the cognitively-based techniques were not appropriate for this client. Although behavioural interventions are commonly the treatment of choice when working with the elderly, the limitations of not using cognitive or schema-focused therapy is reflected in the outcome data that showed the client's dysfunctional negative beliefs remained largely unaffected after treatment.

A number of difficulties were encountered in working with this client. The client's exceeding dependency and neediness and her lack of appropriate boundaries made therapy challenging. Dependent patterns of behaviours are commonly observed in older women raised in traditional Chinese culture, which from a Western perspective may be seen as dysfunctional. However, achieving self-individuation and autonomy is not a conventional repertoire in Chinese culture, where one's sense of self-worth, self-identify, and happiness is connected to, and influenced by one's relationship with others (Yip, 2005). As commented by Yip (p. 397) "traditional Chinese concepts of mental health facilitate a form of passive egocentric preservation which is a form of self-alienation from intense social demands and social inequality". This passive egocentricity was manifested by this client, which was characterized by her demandingness on her friends and therapists, concern

mainly about herself and her problems, her helplessness to make decisions about day to day functioning, avoidant patterns, and an expectation that the mental health system and others would resolve her problems.

According to Stein and Young (1992) people with dependency personality traits have impaired autonomy in that they cannot perceive themselves as able to survive and function independently and to cope with every day responsibilities without considerable help from others. They exaggerate fears about illnesses or disasters that may befall as they do not believe they are capable of protecting and taking care of themselves. To label this client with dependent personality disorder, however, would be an injustice as it does not take into account that her behaviour is not atypical within the context of her cultural background and experiences.

Notwithstanding the above, the client's motivation for treatment could be questioned as she showed evidence of being resistant to making changes. For this client, being symptom-free may not be a realistic goal as it would mean a loss of support and attention from her friends and the mental health system to which she had become dependent upon, in the absence of a family caregiver. Secondary gains and her need to hold on to the symptoms would need to be addressed with her. This could be achieved by increasing her sense of self-efficacy to manage on her own, accepting her situation about being on her own, and improving her communication and interpersonal skills.

In summary, the 5-part model of CBT was partially successful, in helping the client gain insight into the nature of her problems and to have control over aspects of her life, even if she was not fully prepared to do this. It was crucial also that the therapeutic processes were appropriate for the client, that the treatment progress was closely monitored, that firm boundaries were maintained, that the focus remained on the client's therapeutic goals, that a collaborative relationship were developed, and that the therapy was short-term and structured, as these factors contributed to the usefulness of the CBT framework. It may be that

the client would benefit from booster sessions at a later stage to assess the extent to which the gains from therapy have been maintained and are generalised. Thus, CBT has shown to be useful in treating Chinese people as long as cultural considerations are taken into account when formulating the problem and in carrying out treatment.

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Notes

1. All names and some personal details have been changed to protect confidentiality
2. This comment was rightfully noted by one reviewer as reflecting negatively on the client. Whilst not wishing to judge the client's comment, it is provided as typical of Chinese candidness and possibly pragmatism.

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