

Indigenising Cognitive Behavioural Therapy: counselling older Chinese people with multiple diseases

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ABSTRACT

Cognitive Behavioural Therapy (CBT) is effective when counselling older Chinese people suffering multiple diseases to change irrational thoughts into more positive ones and reduce their distress. Citing examples from counselling sessions with two older women suffering from multiple and crippling diseases, this paper identifies how CBT can be put into practice, by helping people recognise their automatic or negative thoughts, how to use gentle confrontation to challenge those thoughts, and how to consider alternatives, construct positive views and develop problem-solving behaviour. At the same time, some CBT practice adaptations are proposed to enhance its effectiveness, including making it culturally sensitive, the building and use of a good client-counsellor relationships as a platform for change, the recall of past experiences, the provision of concrete assistance along with working at the cognitive and/or behavioural levels, and use of a slower pace to meet the physical and mental abilities of older clients.

Key words: Aged; Cognitive therapy; Combined modality therapy; Counseling; Pain

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INTRODUCTION

"I can't be a volunteer again! I can't go out freely by myself! I'm just a worthless person. No one will care about me. Being alive is suffering," said Sin.

"Don't ask me to participate in any activity since I would be sick while going out. I still remember I got dizzy in the restaurant last year and the institute's staff had to take me home immediately. It is so embarrassing!" said Lee.

These are statements made by two older women who suffered from multiple and disabling illnesses and who lived in a home for the elderly in Hong Kong. Similar remarks are not uncommon among older people facing chronic and multiple illnesses. Their responses could be attributed to being upset by their physical suffering, to pain, feelings of uselessness, and/or fear of death. They are subject

to multiple physiological and psychosocial stressors and may be threatened with many potential losses and lifestyle changes.

According to the Study on Persons with Disabilities and Chronic Illness conducted by the Census and Statistics Department of the Hong Kong Special Administrative Region Government,¹ there were 344 000 persons with disabilities and 882 700 persons with chronic illnesses, representing 5% and 13% of the Hong Kong population (year 2000) respectively. The disabilities and illness levels may be even higher among older people. Older people may face a lot of losses, including loss of their job, loss of functional abilities, and loss of loved ones. If they also suffer from multiple and disabling illnesses, they may experience major psychosocial challenges which impact negatively on their self concept, leading to anxiety, depression and a feeling of inadequacy. Some of their physiological stressors are pain, discomfort,

restrictions on their physical activities, fatigue, and weakness.

Even though physical illness is the most common stressor leading to adjustment problems and a depressed mood, clients may still be able to reduce their distress by changing repetitive thoughts about their various health and adjustment issues.² One strategy is to adopt Cognitive Behavioural Therapy (CBT), aiming to eliminate the client's 'irrational' thinking.

The first author has applied CBT when working with 10 chronically ill residents of an aged home from January 2006 to June 2006, as her counselling practicum for a Master's Degree in Social Science in Counselling at the City University of Hong Kong. The second author was her practicum supervisor. The therapy was found to be a particularly appropriate counselling approach for older people with multiple physical illnesses. Using two cases to illustrate the discussion, this paper describes ways in which CBT can be applied to enable older people to alter destructive beliefs about their illnesses, and thus help them to adapt more effectively to their new life.

It is also proposed that some CBT practice principles be adapted to enhance its effectiveness in this particular setting, taking into consideration the value systems and cultural heritage of Chinese older people, the need to build and use a good client-counsellor relationship as the platform for change, the value of recall of past experiences and of the provision of concrete assistance while working at the cognitive and/or behavioural levels. Some information about the two clients involved follows:

Sin was 75 years old. She was a widow who had two daughters. Her younger daughter had migrated to Canada and the client lived with the elder one before being admitted to a home for the aged 4 years ago. She had suffered serious rheumatoid arthritis since mid 2005, with deformities to both hands and fingers. She was also found to have polyarthralgia in November 2004.

Sin had been an active volunteer at a centre for the elderly but, after the onset of her disease, her mobility deteriorated so sharply that she

could no longer participate in voluntary services. She avoided talking about her feelings and the suffering caused by her illnesses. She only expressed her reluctance to bother others who took care of her. Half a year ago, she began to exhibit violent behaviour: she bit herself and then went on screaming. She even claimed that her illnesses were due to a curse from her roommate who was demented.

Lee was aged 73. She had lived with her husband in a couple-room since 2002. She suffered multiple illnesses: multiple cerebral infarcts, anaemia, osteoporosis, Parkinson's disease and had a recent left cerebral vascular accident. Lee also had a history of anxiety neurosis since 1998.

Lee's husband also had numerous health problems, such as gallbladder stones, acute cholecystitis, hypertension, lung cancer, nasopharyngeal carcinoma, lower urinary tract symptoms, and a left neck mass. Lee was worried about her husband's health and did not expect much psychological and physical support from him. Despite this their relationship was good, even though the husband was quite dominant and self-centred. He seldom talked with other residents or even with Lee, giving her little chance of verbalising her frustrations or speaking frankly about her feelings. Because both were in poor health, the couple always stayed in bed and seldom joined in the social life at the home.

COGNITIVE BEHAVIOURAL THERAPY

Beck et al³ pointed out that how a person appraises a situation is generally evident in his cognitions. These cognitions constitute the person's stream of consciousness or phenomenal field, which reflects the person's configuration of himself/herself, his/her world, his/her past and future. Any alterations in the content of the person's underlying cognitive structure affect his/her affective state and behavioural patterns.

Ellis et al⁴⁻⁶ developed the ABC theory as a core concept in Rational Emotive Behavior Therapy and this has become one of the most popular forms of CBT. According to this concept, emotional and behavioural consequences (C) result from beliefs (B) about activating events (A).

Some people overestimate risks or danger, and underestimate their ability to cope, something Ellis calls “catastrophising”. This pattern was seen in the cases quoted above. Older people who need help are struggling with problems that are very real to them; very often they have to endure debilitating and demanding medical treatments. In fact, sadness over multiple and disabling illnesses is a normal reaction; but clinical depression or anticipating that “my life is over” or “I cannot go out” is likely to be due to catastrophising or overgeneralisation of the causes or effects of bad events.

Unlike most psychotherapy, CBT does not delve into childhood, but deals with the present. The therapy is based on the assumption that both cognitive and behavioural responses to events are learned. For this reason, the therapy is constructed as a collaborative enterprise, with therapists as respectful teachers who enable clients to understand themselves better, examine their beliefs critically, and develop more constructive ways of coping. So, through the therapy, clients can be helped to new ways of thinking and thus avoid their unrealistic sadness.

To help alleviate clients’ distress and enhance their coping and problem-solving abilities, CBT incorporates both behavioural and cognitive strategies. Yost et al⁷ suggested that, during CBT, behavioural components be introduced to the helping process. Behavioural approaches applied in the above two cases were relaxation training and modelling,⁸ teaching self-management and monitoring,⁹ and participation in various activities. Cognitive skills employed in the therapy included, first, discovering clients’ basic irrational beliefs; second, disputing these irrational ideas¹⁰; third, reconstructing a positive cognitive framework^{11,12}; and, finally, changing the clients’ negative or maladaptive thoughts into more healthy ones,⁸ leading to more positive emotions.

INDIGENISING COGNITIVE BEHAVIOURAL THERAPY PRACTICE

Clients suffering from multiple, chronic, and disabling illnesses tend to be very frustrated. They may withdraw from activities prematurely because of fear of embarrassment when mixing with others, or they may become passive from long suffering, with little motivation to initiate any kind of change. Some

may avoid problem-solving tasks. All these can spiral downwards into catastrophic thinking, making them feel useless and hopeless.

A common practice in CBT is elimination of the client’s irrational thinking through cognitive change and the provision of skills training to enable them to feel more effective in their daily life. The following paragraphs illustrate how CBT can be put into practice when working with older people suffering from severe physical illnesses, including helping them recognise their negative thoughts, dispute these irrational thoughts using gentle confrontation, and construct positive views. At the same time, some adaptations of CBT practice principles are required to enhance its effectiveness and cultural sensitivity.

PRACTICE WISDOM IN DIRECT APPLICATION OF COGNITIVE BEHAVIOURAL THERAPY PRINCIPLES

Prerequisites of clients

For CBT to be effective, clients need to have some prerequisites.¹³ First, the client must be verbally competent and have no cognitive impairment because CBT requires clients to identify thoughts and discuss feelings. Second, the ability to engage in abstract thinking and analyse behaviour is the cornerstone of the CBT approach. Additionally, clients must be able to self-disclose and be willing to do so with the counsellor. The therapy has not been very effective for elderly people who are highly autonomous or have extreme difficulty with asking for or receiving help.¹⁴

So before commencing any intervention, there is a need to assess whether clients can fulfill these prerequisites. This is especially crucial for old-old women, many of whom are illiterate and have very limited life experiences, thus making it more challenging for them to engage in abstract thinking, to analyse their own behaviour, and to examine the underlying schema. Therefore, in the initial contact with Sin and Lee, information about their literacy and working experiences were explored. Both of them were found to be literate and had joined the work force in their youth. Indeed, Sin’s verbal ability was above average because she had been a volunteer for many years and therefore had many opportunities to interact with other people.

Making the structure of therapy explicit

Cognitive Behavioural Therapy is a structured and short-term psychotherapy; treatment is directed towards helping patients to reach explicit goals agreed at the start of the intervention and at each meeting.¹⁵ Elderly people suffering multiple illnesses usually present with a range of problems: some problems have existed for a long time, while some are more recent (such as a quarrel with a roommate). To make the treatment as productive as possible, therapists need to make the structure of therapy explicit to their clients. With Sin, even though she had numerous problems including relationship problems with her daughters and her roommates, the counsellor identified, together with her, that the main concern was her pain problem. This specific goal was mentioned at the start of each session, and the discussion would always focus on this. Sometimes Sin would start with other problems, e.g. a recent conflict with her roommate, and the counsellor would allow her to ventilate for a while, but would direct her to the pain problem once Sin had settled down a bit.

Clients' self-determination

During the counselling process, the client's will and readiness are important. The therapy is a self-debating process. If clients are willing and committed, they can come up with alternate thinking. So, the counsellor helps clients to decide whether they prefer to stay with the present situation or to lead a new life. Here is what the counsellor raised with Lee after rapport was established, "Do you prefer not to do anything to stop your health from deterioration?" With the counsellor's unconditional support and empathy, Lee expressed the need to change her perception in a more positive way, and indicated her readiness to join more activities in the aged home.

Acknowledging irrational thoughts

Through careful questioning and discussion or "guided discovery",¹⁶ the clients were helped to identify obvious evidence about inaccurate and irrational perceptions. They were then helped to acknowledge that holding a rigid attitude was producing their emotional distress and preventing them from pursuing meaningful and satisfying

activities. For instance, Lee was asked to supply proof that staying in her room was better for her health and mood than joining activities.

Using gentle confrontation

Two major causes of frustration are the physical restrictions patients are forced to accept and the pain and suffering brought about by their diseases. These frustrations are sometimes too much for them; as a result, they lose motivation for change. Lee, for example, found it hard to find ways to reduce her suffering. It has been found that confronting such clients gently might enable them to explore options and take some positive actions. Thus, in the interview with Lee, the counsellor agreed with her difficulty but confronted her preference for employing a self-defeating way to handle her situation. Confrontation in a friendly, caring and non-threatening way such as "Yes, I agree it would be hard to change, but do you prefer not to do anything to stop your health from deterioration?" This question helped Lee critically examine her own thought processes. It also conveyed a message that the counsellor cared about and recognised her sufferings. In response to the question, Lee was silent at first. Afterwards, she revealed that she preferred death to life. To clarify her intention, the counsellor further confronted her with the suggestion that it may not be what she really wanted since she loved her family very much. After musing upon what the counsellor said for a while, Lee confessed that death was not her choice for she would not like to leave her son. This guided discovery stimulated her to face an avoided situation and to think differently and less destructively.

Cognitive reconstructing

An awareness of dysfunctional thoughts is not enough; elderly people must take active steps to facilitate more positive feelings as well as to regain mastery over their lives.

Sin, who suffers from serious rheumatoid arthritis leading to deformed fingers and hands, received inadequate attention from her doctor when she complained about the poor effects of her pain control medication. Under the perception widely held by older people that the doctor is an authority figure, she did not elaborate on her situation further, but

simply stopped taking the medicine. This resulted in her daily activities being seriously hampered by her pain problem, to the extent that she could not even comb her hair or get dressed. Helping Sin to alleviate her dysfunctional thinking pattern, the counsellor suggested that Sin re-evaluate her response towards doctors. Could one doctor's reaction be generalised to all doctors? Did she try to reveal her situation to other doctors and receive similar treatment? The counsellor understood that Sin did not have self-confidence, so reminded her of a patient's right to proper treatment.

Clients were helped to diminish negative self-talk, to reframe obstacles as challenges, and to expand their consideration of possibilities and alternatives. In Sin's case, the counsellor showed her that there were many frail or demented residents in the institution needing help so she could, despite her poor health, still contribute and be a volunteer, serving in ways that might be different from what she did in the past. This enabled her to identify her self-defeating beliefs, such as, "I am no good because I have rheumatoid arthritis" or "My mobility problem means I'll not lead a quality life"; and to replace them with more self-enhancing beliefs (e.g. "My mobility problem cannot stop me from going out and enjoying my life," or "My mobility problem has nothing to do with my ability to contribute to other residents since there are many different ways to serve others").

Very often, older people find it difficult to come up with positive or alternative thoughts. The counsellor can help them to recall positive experiences from the past. For example, the counsellor reminded Lee of happy episodes such as having tea with other residents in a restaurant in order to motivate her to participate in social activities. Or, clients can be invited to explore what is controllable in their lives (like exercising every morning) rather than what they cannot control (like ending the illnesses). Since it takes time for elderly people to consolidate these cognitive techniques, make connections and generate "alternative thoughts", the therapist's patience and support are very important.

Use of behavioural strategies

Cognitive Behavioural Therapy helps to correct distorted thinking but heavy reliance on reasoning is simply neither appropriate nor effective for older

people. Behavioural strategies, when employed in very specific ways, can make a great deal of difference toward bringing satisfaction to clients and motivating them to change.

Clients were helped to understand and accept that they were in a state of loss. Instead of confining themselves to mourning that loss, they were encouraged to cope with their problems by resuming some social life or physical activities. For example, Lee always claimed she was too frail to join any activities. Her responses encouraged others not to invite her to participate in any activities. As a result, her life became more dull and miserable. To break the vicious cycle, the counsellor invited her to come and enjoy the soft breeze in a nearby park. At first, she was rather reluctant to try this. It took a lot of encouragement to get her to agree to go out. To increase her enjoyment, she was encouraged to smell and touch the plants. After enjoying the walk, her confidence and interest in activities were strengthened. Afterwards, she became quite ready to attend other activities. Her mood as well as her physical condition improved.

At other times, clients were encouraged to read positive and calming self-statements, and for those with religious beliefs, to read from religious literature, in order to reduce their negative emotions. These behavioural strategies could be incorporated as 'homework' and given to them to complete after counselling sessions.

ADAPTATION OF COGNITIVE BEHAVIOURAL THERAPY PRACTICE PRINCIPLES

Adaptations to CBT principles arising from direct counselling practice with 10 chronically ill older Chinese are as follows:

Cultural considerations

To be effective, CBT must build on an accurate understanding of the value system, the cultural heritage, and life circumstances of the clients. Cultural factors that are of special relevance to CBT are as follows:

Harmony and face-saving

Harmony and face-saving are two important

communication characteristics among Chinese people.¹⁷ In order to maintain harmony and face-saving, Chinese people prefer indirectness, implicitness, and non-verbal expressions instead of aggressive, argumentative and confrontational modes of communication.¹⁸ That was possibly why both Sin and Lee were initially hesitant about revealing their concerns and true emotional responses. They considered it a loss of face to reveal their personal problems to people who are not their family members, relatives or friends. Moreover, they worried that their problems were too trivial to take up the counsellor's time. In response to these communication characteristics, the counsellor needed to be alert to their every verbal and non-verbal communication, and was active in exploring their hidden problems and emotional reactions.

External locus of control

Most Chinese people believe that they are controlled by external forces such as fate, luck, or chance; hence they tend to de-emphasise themselves in favour of the group. Lee was silent and not motivated to join any outdoor programmes. After some rapport had been built between her and the counsellor, she admitted that once, during a New Year celebration dinner, she experienced dizziness and the institution had to spare a staff member to take her to see a doctor immediately. She saw her sickness as creating a nuisance for the staff and residents, considered herself a burden and never participated in any outdoor activities again. So, to encourage Lee's involvement in activities, the counsellor told her that no one can stop herself from feeling sick and staff members were actually always ready to provide help in time of need. Lee's disclosure demonstrates the importance of support; it could help Lee face negative experiences squarely and see them in a new light.

Unfamiliarity with psychotherapy

Older Chinese people seldom go to counsellors to handle their emotional problems. There are far fewer psychotherapists and counsellors than physicians in Chinese societies, including Hong Kong. Because there is little understanding about counselling and a lack of access to the service, very few older Chinese look to psychotherapists for professional help; they usually only approach physicians for their emotional problems.^{19,20} This also happened with the 10 clients the first author worked with. None

of them voluntarily sought the counselling service; all were referred by nurses in the home. To enhance the clients' acceptance of the counsellor as a member of the helping professions, the counsellor paired up with the nursing staff and took health issues as the entry point for the counselling work.

Providing a well-structured and hierarchical environment

The Chinese socialisation process emphasises hierarchy and defined roles and responsibilities.^{17,21} Most Chinese traditionally exhibit deference to those in power.²² The counsellor therefore played an active role in providing Sin and Lee with concrete suggestions and advice when they could not identify options and different perspectives. This form of relating corresponds to the authoritarian nature of social relationships in Chinese culture.²³ Nevertheless, the ultimate target is still to empower clients to see that there are alternatives and that they are capable of solving their own problems.

Good client-counsellor relationship

In CBT, the therapeutic relationship is seen as an essential ingredient, but, unlike other psychotherapies, it is not taken as the main vehicle of change.¹⁶ Our clinical experiences suggest that establishing a good and reliable client-therapist relationship is important for effective intervention. The rapport helps clients become willing to venture out, to reveal their concerns and to identify their underlying schema to the counsellor. It also fits the clients' needs as, facing losses in health and being of advanced age, these clients long for concern and support.

How do therapists build up relationships with older clients? Our working experience demonstrates that it is important that counsellors see their working strategies in terms of clients. Older adults have, in some ways, more complex and subtle emotions than younger adults. The clients are often physically weak and have poor memories. In addition, due to the need to save face, older people tend to exercise emotional restraint and self-control.²⁴ They tend to be reluctant to express or discuss their thinking or emotions. To facilitate relationship building, counsellors need to listen actively and empathetically; counsellors should repeatedly help clients to clarify their ideas about what they expect to change through participating in the counselling process. On the

other hand, the counsellor should be sensible and tactful about the timing and frequency of visits (e.g. short but frequent contacts/greetings at the start of the intervention), and about their responses to clients' queries. At times, the visits to Sin and Lee were devoted solely to the supportive therapy tactics of calming and offering advice, or ventilation of rage inspired by an insult from, for example, a relative or a roommate.

When working with older people who are critically and chronically ill, we need to be sensitive to their feelings. Pushing them to speak up does not work. Active listening and a show of empathy are much appreciated by clients. During the 6-month practicum, upon finishing an interview, the counsellor was told numerous times, "Thanks for listening", or "I'm glad that I was finally heard". These mean more than "Thanks for the advice/help", even though many Chinese clients expect counsellors to take on active, authoritarian roles, providing guidance and suggestions. Clients' appreciation of therapists' understanding and empathy was highlighted by Kuehl et al²⁵ as early as 1990. They found that a therapist's caring and understanding attitude, ability to generate relevant suggestions, and flexibility were features especially valued by clients. Given the emphasis put on collaboration by CBT,²⁶ providing empathy and taking account of the older person's perspective are all valuable tools contributing to the effectiveness of therapy. Research has also clearly indicated that, in CBT, like other forms of therapy, a positive therapeutic alliance is an essential component of effective therapy.^{27,28}

Reminiscences

Even though CBT focuses on the present, we found that selective use of reminiscence when counselling elders will bring about several positive results. First, many older clients want to talk about the past and resent being stopped. Second, clients feel the counsellor cares and listens. They feel respected and become more receptive to the counsellor and the counselling process. Third, recalling past happy experiences often generate joy and a positive mood.^{29,30} Fourth, reminiscences may be taken as a reworking of the client's life span; and might take the client toward a more abstract level of cognitive intervention. Finally, it may eliminate their feelings

of uselessness as it did for Lee, who was very proud when recalling how she learned to read in her younger days. Sin also expressed a sense of satisfaction when she illustrated how tough she was by raising her two daughters all by herself.

Provision of concrete assistance

It is important to solve specific problems that are solvable when adopting CBT in psychotherapy. Older people can become overwhelmed when they do not get enough help to deal with their individual problems. Therefore the counsellor joined with nursing staff to equip Sin and Lee with information about managing their physical illnesses. With more understanding about their health, Sin and Lee better collaborated with staff to promote health. For example, they showed initiative by reporting any changes to their health and held a more positive attitude towards their illnesses.

The counsellor also accompanied Sin to a medical appointment in order to provide moral support while she expressed her concerns about her pain control to the physician. Noticing that Sin was overwhelmed by a depressive mood, the counsellor accompanied her when exercising or walking in nearby parks, in order to motivate her and to create a better environment for change.

Slower pace

Due to clients' poor physical health and mental abilities, the pace of the therapy needs to be slowed down. For example, Lee, whose cognitive ability was hindered by multiple illnesses, could not manage a lot of information and had a short attention span. The speed of therapeutic conversation and the amount of cognitive work done was consequently reduced. It was also necessary for the counsellor to frequently repeat what the clients were to learn, such as breathing exercises and positive thinking styles and to ask them to repeat these in order to be sure that they understood. Also, counselling sessions could not be long, usually lasting only half an hour or so.

CONCLUSIONS

The increase in life expectancy brings a set of physiological and psychological challenges for

severely and chronically ill older people. Our clinical experiences confirm that CBT psychotherapeutic techniques effectively enable Chinese older patients suffering chronic and multiple diseases to discover their automatic thoughts, and to move away from more extreme and unhelpful ways of perceiving things to more helpful and positive ideas and behaviours.

It is strongly recommended that, to be more effective, CBT practice principles be adapted to take into account cultural factors affecting older people. The adaptation should include the building of and use of a good client-counsellor relationship as a platform for change, the recall of past experiences, the provision of concrete assistance in addition to working at the cognitive and behavioural levels, and using a slower pace to fit in with the physical and mental abilities of older clients.

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