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Cultural Issues in the Treatment of Depression Among Chinese

Kenneth Fung MD FRCPC MSc
Assistant Professor
Department of Psychiatry, University of Toronto
Clinical Director
Asian Initiative in Mental Health, University Health Network

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Disclosure / Conflict of Interest

- *None*

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Learning Objectives

1. Describe a cultural competent framework towards the treatment of mental disorders.
2. Identify diagnostic challenges of mood disorders due to cultural issues.
3. Formulate treatment plans for mood disorders, including psychotherapeutic interventions, taking cultural issues into account.

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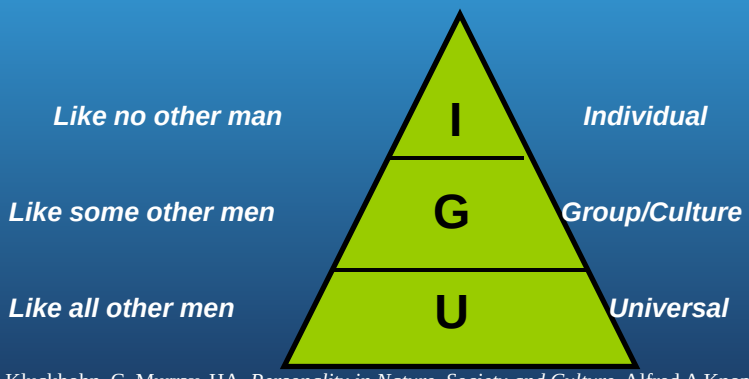
Kluckhohn Triangle

Every man is, in certain respects:



Kluckhohn, C, Murray, HA. *Personality in Nature, Society and Culture*, Alfred A Knopf, New York, 1962.

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Cultural Competence

- "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations"

Terry Cross et al (1988)

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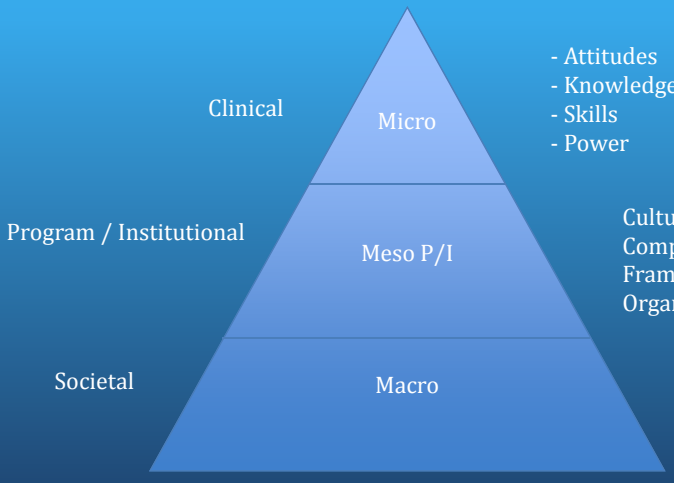
The 3 Levels of Cultural Competence



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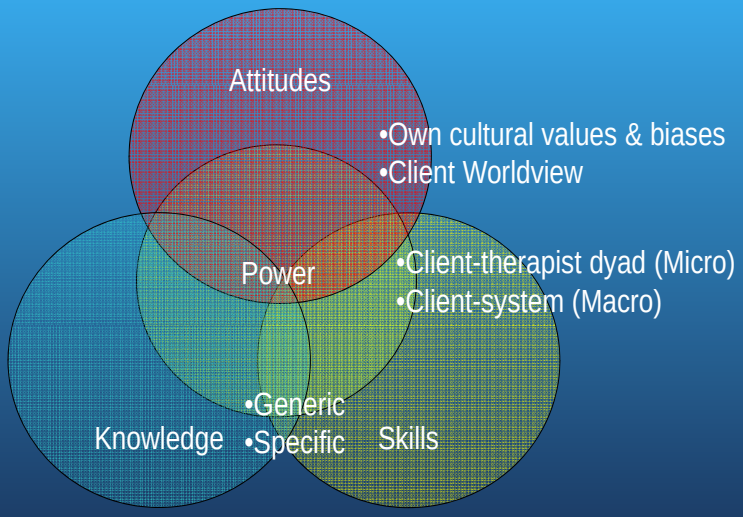
Clinical Cultural Competence Practice Components/Competencies



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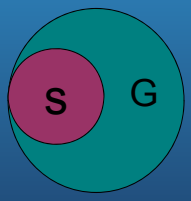
Generic vs Specific Cultural Competence

GENERIC

- Culture – broadly defined
- All cultural interface
- For all clinicians
- Integrated
- Process - CF
- Consultation



SPECIFIC

- Culture – ethnoracial
- Specific populations
- Interested clinicians
- Subspecialty
- Stand-alone course
- Content - CBS
- Ethnospecific service

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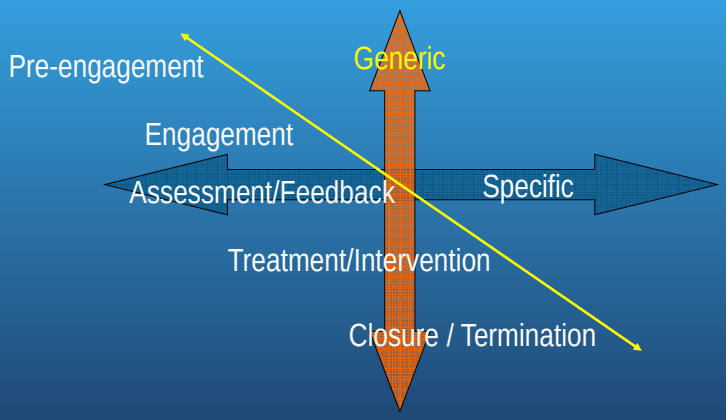
Clinical Cultural Competence Practice Components/Competencies



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Assessment & Diagnosis

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Depressive Disorders

- **Major Depressive Episode (> 2 weeks):**
  - **Depressed mood**
  - **Decreased interest**
  - **Weight Loss or Gain / Appetite Changes**
  - **Insomnia or Hypersomnia**
  - **Psychomotor Agitation or Retardation**
  - **Fatigue or Loss of energy**
  - **Feelings of Worthlessness / Guilt**
  - **Decreased concentration or Indecisiveness**
  - **Recurrent thoughts of death / Suicide**

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Depression

- Genetic - Studies on twins show that if one of the identical twins has depression there is a 65-75% chance that the twin sibling also has depression; the incident rate among fraternal twins is 14-19%.
- Neurochemistry - Depression may be related to problems with "neurotransmitters" which are chemicals that are used to pass signals from one brain cell to another brain cell.
- Psychological - Self-esteem, cognitive (e.g. negative thinking).
- Psychosocial and socio-economical - Stress from loss of job, poverty, relationship difficulties, inequitable opportunities in society or experience of other hardships.

Epidemiology of Depression

- Prevalence:
  - Life time: 4.4 – 18%
  - 2:1 - F:M

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WHO Developed/World Data: DALYs 2002

Ischaemic heart disease	19.8	Lower respiratory infections	91.4
Unipolar depressive disorders	15.6	HIV/AIDS	84.5
Cerebrovascular disease	13.7	Unipolar depressive disorders	67.3
Alcohol use disorders	7.7	Diarrhoeal diseases	62.0
Other cardiovascular diseases	6.5	Ischaemic heart disease	58.6
Other unintentional injuries	6.4	Cerebrovascular disease	49.2
Hearing loss, adult onset	5.9	Other unintentional injuries	48.5
Chronic obstructive pulmonary disease	5.6	Malaria	46.5
Other digestive diseases	5.6	Low birth weight	46.3
Road traffic accidents	5.3	Childhood-cluster diseases	41.5
Trachea, bronchus, lung cancers	5.1	Road traffic accidents	38.7
Alzheimer and other dementias	5.0	Tuberculosis	34.7
Self-inflicted injuries	4.8	Birth asphyxia and birth trauma	34.4
Osteoarthritis	4.5	Chronic obstructive pulmonary disease	27.8
Diabetes mellitus	4.0	Other digestive diseases	27.5

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Depression in the Elderly

- Community:
  - 25% - some depressive symptoms
  - 1-9% MDD
- LTC:
  - 10-22%

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Risk factors for late-onset depression

Female sex (female-male ratio, 2.5:1)
Medical illness
Hypothyroidism (50%)
Myocardial infarction (45%)
Macular degeneration (33%)
Diabetes (8% to 28%)
Cancer (24%)
Coronary artery disease (20%)
Medications
Beta-blockers
Interferon alfa
Many anticancer drugs
Central nervous system disease
Parkinson's disease (25% to 70%)
Alzheimer's disease (15% to 57%)
Multiple sclerosis (27% to 54%)
Stroke (26% to 54%) esp. L/F
Huntington ‘s disease (9% to 44%)
Microvascular ischemic disease of the brain (20%)
Mini-Mental State Examination score <24

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Depression in the Elderly

- apathy
- memory problems
- confusion
- social withdrawal
- loss of appetite
- inability to sleep
- irritability
- Delusions and hallucinations
- severe feelings of sadness, but not acknowledged
- persistent and vague complaints and help seeking
- frequent calling and demanding behavior

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Differentiating between dementia and the dementia syndrome of depression

Signs and symptoms	Depression	Dementia
Onset	Abrupt, rapid decline	Slow, insidious
Sleep problems	Early awakening	No specific pattern
Diurnal variation	Worse in morning	Sun-downing present
Electroencephalogram	Normal	Abnormal
Dexamethasone suppression test	No suppression	Normal
Thyrotropin-releasing hormone test	Blunting	Normal
Antidepressant trial	Response	No response

Depression in the Chinese

- Existing epidemiologic studies tend to report very low rates:
  - lifetime prevalence of affective disorder = 0.08% in 7 regions of China (Zhang 98)
  - lifetime prevalence of depression: 1.5% in Taiwan (vs 2.9 - 19 % elsewhere) (JAMA 96)
  - Low rates of depression found in over-seas Chinese compared to local population

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Table 2. Twelve-Month Prevalence of World Mental Health Composite International Diagnostic Interview/*Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition**

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Country	% (95% Confidence Interval)				
	Anxiety	Mood	Impulse-Control	Substance	Any
Americas					
Colombia	10.0 (8.4-11.7)	6.8 (6.0-7.7)	3.9 (3.2-4.7)	2.8 (2.0-3.7)	17.8 (16.1-19.5)
Mexico	6.8 (5.6-7.9)†	4.8 (4.0-5.6)	1.3 (0.9-1.8)‖	2.5 (1.8-3.3)	12.2 (10.5-13.80)
United States	18.2 (16.9-19.5)	9.6 (8.8-10.4)	6.8 (5.9-7.8)	3.8 (3.2-4.5)	26.4 (24.7-28.0)
Europe					
Belgium	6.9 (4.5-9.4)	6.2 (4.8-7.6)§	1.0 (0.3-1.8)‖	1.2 (0.6-1.9)‡‡	12.0 (9.6-14.3)
France	12.0 (9.8-14.2)	8.5 (6.4-10.6)§	1.4 (0.7-2.0)‖	0.7 (0.3-1.2)‡‡	18.4 (15.3-21.5)
Germany	6.2 (4.7-7.6)	3.6 (2.8-4.3)§	0.3 (0.1-0.6)‖	1.1 (0.4-1.7)‡‡	9.1 (7.3-10.8)
Italy	5.8 (4.5-7.1)	3.8 (3.1-4.5)§	0.3 (0.1-0.5)‖	0.1 (0.0-0.2)‡‡	8.2 (6.7-9.7)
Netherlands	8.8 (6.6-11.0)	6.9 (4.1-9.7)§	1.3 (0.4-2.2)‖	3.0 (0.7-5.2)‡‡	14.9 (12.2-17.6)
Spain	5.9 (4.5-7.3)	4.9 (4.0-5.8)§	0.5 (0.2-0.8)‖	0.3 (0.0-0.5)‡‡	9.2 (7.8-10.6)
Ukraine	7.1 (5.6-8.6)†‡	9.1 (7.3-10.9)§	3.2 (2.4-4.0)¶#**	6.4 (4.8-8.1)‡‡	20.5 (17.7-23.2)
Middle East and Africa					
Lebanon	11.2 (8.9-13.5)	6.6 (4.9-8.2)	1.7 (0.8-2.6)¶**	1.3 (0.0-2.8)	16.9 (13.6-20.2)
Nigeria	3.3 (2.4-4.2)	0.8 (0.5-1.0)	0.0 (0.0-0.1)¶#**	0.8 (0.3-1.2)	4.7 (3.6-5.8)
Asia					
Japan	5.3 (3.5-7.0)†	3.1 (2.2-4.1)	1.0 (0.4-1.5)¶#**††	1.7 (0.3-3.0)	8.8 (6.4-11.2)
People's Republic of China					
Beijing	3.2 (1.8-4.6)†	2.5 (1.5-3.4)	2.6 (1.3-3.9)¶#**	2.6 (1.2-3.9)	9.1 (6.0-12.1)
Shanghai	2.4 (0.9-3.9)†	1.7 (0.6-2.9)	0.7 (0.4-1.1)¶#**	0.5 (0.3-0.6)	4.3 (2.7-5.9)

*Anxiety disorders include agoraphobia, generalized anxiety disorder, obsessive-compulsive disorder, panic disorder, posttraumatic stress disorder, social phobia, and specific phobia. Mood disorders include bipolar I and II disorders, dysthymia, and major depressive disorder. Impulse-control disorders include bulimia, intermittent explosive disorder, and reported persistence in the past 12 months of symptoms of 3 child-adolescent disorders (attention-deficit hyperactivity disorder, conduct disorder, and oppositional-defiant disorder). Substance disorders include alcohol or drug abuse or dependence. In the case of substance dependence, respondents who met full criteria at some time in their life and who continue to have any symptoms are considered to have 12-month dependence even if they currently do not meet full criteria for the disorder. Organic exclusions were made as specified in the *Diagnostic and Statistical Manual of Mental Health Disorders, Fourth Edition*, but diagnostic hierarchy rules were not used.
†Obsessive-compulsive disorder was not assessed.
‡Specific phobia was not assessed.
§Bipolar disorders were not assessed.
‖Intermittent explosive disorder was not assessed.
¶Bulimia was not assessed.
#Attention-deficit hyperactivity disorder was not assessed.
**Oppositional-defiant disorder was not assessed.
††Conduct disorder was not assessed.
‡‡Only alcohol abuse and dependence were assessed. No assessment was made of other drug abuse or dependence.

JAMA 2004

	Unweighted n	Weighted Percentage/ Mean	SE	Lifetime Prevalence of Any Disorder %	SE	12-Month Prevalence of Any Disorder %	SE
Gender							
Men	998	47.45	1.12%		2.39%		1.36%
Women	1097	52.55	1.12%		1.68%		1.15%
Age	2095	41.33	0.88				
Ethnic origins							
Filipino	508	21.59	2.32%		1.40%		1.26%
Vietnamese	520	12.93	2.09%		2.40%		1.38%
Other Asians	467	36.79	2.34%		2.81%		1.56%
Nativity status							
English-language proficiency							
Years in the United States							
US-born	454	23.07	3.21%		3.22%		1.96%
0–5	302	14.17	1.98%		3.02%		1.50%
6–10	300	12.06	1.06%		2.89%		2.74%
11–20	532	26.46	1.70%		1.55%		1.09%
≥21	504	24.25	1.24%		2.17%		1.37%
Age at time of immigration, y							
US-born	454	23.07	3.21%		3.22%		1.96%
≤12	237	12.72	1.43%		4.43%		3.31%
13–17	130	5.08	0.56%		3.89%		2.95%
18–34	886	41.64	2.31%		1.66%		1.00%
≥35	385	17.49	1.84%		2.68%		1.55%
Generational status							

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F: D/A/S
M: S

M: D/A

F: D/S

Takechui et al, 2007

Lower rates in Chinese?

- Cultural protective factors
  - Stronger social support
  - Tolerance/Forbearance
  - Different belief systems, e.g. fate
- Stigma
- Diagnostic Issues
  - Neurasthenia
- Somatization

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Cultural Bound Syndromes

- Koro
- qi-gong psychotic reaction
- Shenjing shuairuo

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Neurasthenia

Figure 1. Chinese symptom configuration of neurasthenia.

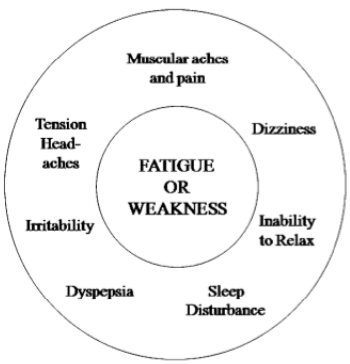

Figure 2. Diagnostic and Statistical Manual of Mental Disorders symptom configuration of neurasthenia as a somatoform disorder.

Lee and Kleinman, 2007

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DSM-IV Cultural Formulation

I. Cultural Identity: ethnicity, language, involvement with culture of origin and host culture

II. Explanatory Model - Cultural explanations of the illness; help seeking experiences and plans

III. Cultural Factors in the psychosocial environment: stressors and supports

IV. Cultural Elements of the clinician-patient relationship

V. Overall Cultural Assessment

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Bi-dimensional Model of Acculturation

		Maintenance of Heritage Culture & Identity	
		High	Low
Maintenance of Mainstream Culture & Identity	High	**Integration** *Multiculturalism*	**Assimilation** *Melting Pot*
	Low	**Separation** *Segregation*	**Marginalization** *Exclusion*

Berry 2002

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ii. Explanatory Models (Kleinman)

1. What do you think caused your problem?
2. Why do you think it started when it did?
3. What does your sickness do to you? How does it work?
4. How severe is your sickness? How long do you expect it to last?
5. What problems has your sickness caused you?
6. What do you fear about your sickness?
7. What kind of treatment do you think you should receive?
8. What are the most important results you hope to receive from this treatment?

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Table 4
Standardized coefficients (beta) from multiple regression of perceived causative categories, perceived access, age, education, and acculturation on ATSPPHS

	Chinese				
	A Hong Kong	B China	C Taiwan	D Korean	E Vietnamese
Stress	0.262**	0.032	0.162	0.151	0.020
Western physiological	−0.060	0.134	0.018	0.109	0.084
Non-Western physiological	−0.065	−0.053	−0.153	−0.057	−0.175
Supernatural	−0.268**	−0.063	−0.194*	−0.128	−0.056
Access	0.090	0.283**	0.208**	0.220**	0.278**
Age	−0.016	−0.049	0.023	0.056	0.013
Education	0.093	0.056	0.061	0.079	0.074
VIAH	0.000	−0.082	0.031	−0.093	0.074
VIAM	0.071	−0.059	0.176*	0.193*	−0.002

* $p < 0.05$; ** $p < 0.01$

Fung et al, 2007

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	Hong Kong Chinese (n=100)	Mainland (n=100)	Taiwan (n=101)	Korean (n=100)	Vietnamese (n=100)
Stress reaction	30.0%	41.0%	47.5%	42.0%	46.0%
Depression	31.0%	30.0%	19.8%	29.7%	9.9%
Schizophrenia/Paranoid Schizophrenia	5.0%	4.0%	3.0%		6.9%
Mania			1.0%		2.0%
Anxiety	3.0%	6.0%	3.0%	1.0%	17.8%
Physical 'weakness'/imbalance/illness	5.0%	2.0%	5.0%	6.9%	2.0%
Mental or Emotional 'weakness'/imbalance/illness	9.0%	12.0%	9.9%	7.9%	8.9%
Personality or Character problem				2.0%	1.0%
Lifestyle/behavioral problem	1.0%		2.0%	4.0%	1.0%
Possession or state caused by other spiritual or magical influence					
Uncontrollable fate or destiny	2.0%			2.0%	1.0%
There is nothing wrong with John/Mary			1.0%		
I don't know			1.0%	2.0%	1.0%
Other	15.0%	7.0%	6.9%	2.0%	2.0%

Table 10: Depression Vignette - Problem considered to be the "most likely"*

* some respondents chose two problems as the "most likely" problem

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	Hong Kong Chinese	Mainland Chinese	Taiwan Chinese	Korean	Vietnamese
	%	%	%	%	%
A typical GP (General Practitioner) of family doctor?	64.0	60.0	62.4	47.0	53.0
A typical chemist or pharmacist?	16.0	14.0	18.0	20.0	22.0
A traditional Chinese/Korean/Cambodian/Vietnamese doctor?	24.0	33.0	25.7	23.0	23.0
A counselor?	70.0	67.0	68.3	67.0	66.0
A social worker?	67.0	72.0	64.4	16.0	60.6
A telephone counseling service?	55.0	64.0	54.5	36.0	48.5
A traditional or spiritual healer?	9.0	14.1	10.2	32.0	18.0
A psychiatrist?	50.0	69.0	58.4	68.0	70.0
A specialist doctor but not a psychiatrist (e.g. surgeon)?	18.0	19.4	21.0	19.0	14.0
A Psychologist?	68.7	89.0	71.0	27.3	67.0
A family member?	81.0	85.0	80.2	65.0	52.0
A close friend?	84.0	90.0	81.0	70.0	72.0
A neighbour?	26.0	38.8	22.8	40.0	29.0
A naturopath or herbalist?	15.0	22.2	18.0	29.0	20.0
A clergy, minister, priest, monk, or religious leader?	42.0	45.0	48.5	70.0	40.0
An elder?	33.0	50.0	50.5	46.0	27.0
Self? ("Is it likely to be helpful, harmful, or neither if John/Mary tried to deal with his/her problems on his/her own?")	26.0	37.0	18.8	40.0	26.0

Table 12: Depression Vignette - Percentage of respondents rating each potential helper as "helpful" versus other responses

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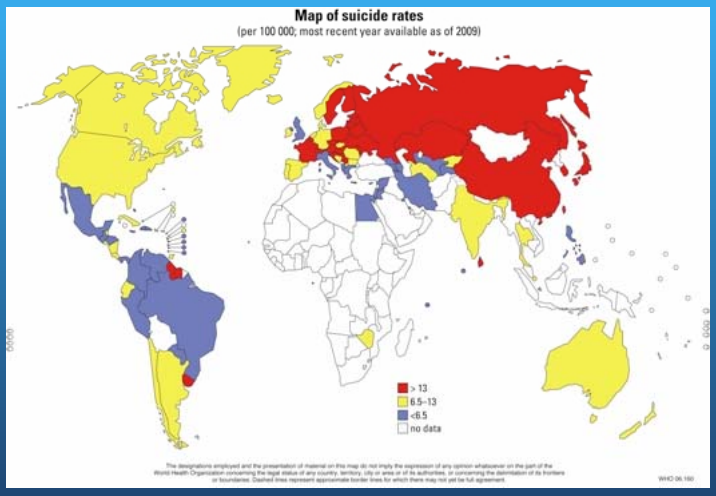
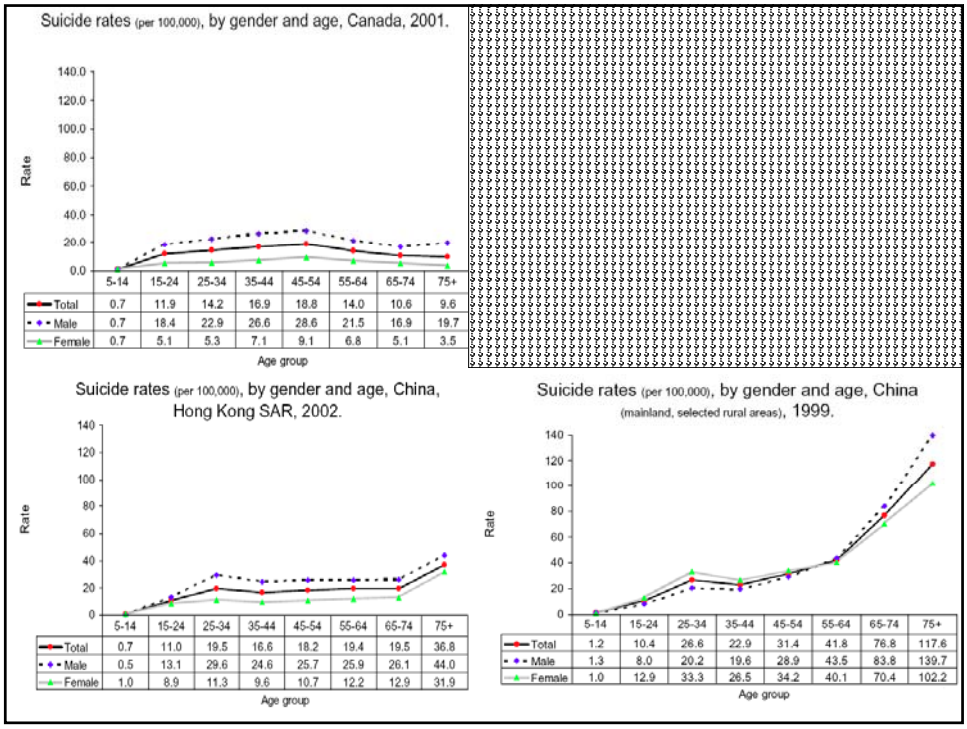

Map of suicide rates
(per 100 000; most recent year available as of 2009)
> 13
6.5–13
<6.5
no data



	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75+
Total	0.7	11.9	14.2	16.9	18.8	14.0	10.6	9.6
Male	0.7	18.4	22.9	26.6	28.6	21.5	16.9	19.7
Female	0.7	5.1	5.3	7.1	9.1	6.8	5.1	3.5

	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75+
Total	0.7	11.0	19.5	16.6	18.2	19.4	19.5	36.8
Male	0.5	13.1	29.6	24.6	25.7	25.9	26.1	44.0
Female	1.0	8.9	11.3	9.6	10.7	12.2	12.9	31.9

	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75+
Total	1.2	10.4	26.6	22.9	31.4	41.8	76.8	117.6
Male	1.3	8.0	20.2	19.6	28.9	43.5	83.8	139.7
Female	1.0	12.9	33.3	26.5	34.2	40.1	70.4	102.2

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	Baseline Intake	Assessments
Cultural Identity		
What cultural groups do you identify with? *What does that mean to you?* (language, values, beliefs, activities, practices in both heritage and mainstream culture) Spirituality (FICA): Faith – *Are you religious or spiritual?* Importance – *How is that important to you?* Community – *How involved are you in your faith community?* Address in Care - *how would you like this addressed in your care here?*	X	
Explanatory Models of Illness		
What do you or your family think caused your problems? *How severe is it and how can one recover?* *Besides prescription medicine, what else do you use to get better?*		X
Sociocultural Stressors and Levels of Functioning		
What kinds of supports do you have from your [family / friends / kin network / cultural, religious and other communities]? *Do you also experience some stress from them?* *How well do you or your community feel you are functioning?*		X
Relationship between clinician and patient		
Given some of our differences and your past experiences, how do you feel about talking with me today?	PRN	PRN

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Pharmacotherapy

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SSRI	
Citalopram (Celexa)	20 – 60 mg
Sertraline (Zoloft)	50 – 200 mg
Fluoxetine (Prozac)	20 – 80 mg
Fluvoxamine (Luvox)	100 – 300 mg
Paroxetine (Paxil)	20 – 60 mg (25-50 mg for CR)
ASRI	
Escitalopram (Cipralex)	10 – 20 mg
SNRI	
Venlafaxine (Effexor XR)	75 – 375 mg
Desvenlafaxine (Pristiq)	50 – 100 mg
Duloxetine (Cymbalta)	60 – 120 mg
NDRI	
Bupropion (Wellbutrin)	150 – 300 mg
a2-adrenergic agonist and 5-HT antagonist	
Mirtazapine (Remeron)	30 – 60 mg
Reversible MAOI-A Inhibitor	
Moclobemide (Manerix)	300 – 600 mg

CANMAT 2009

Recommendations for Non-response and Incomplete Response to an Initial Antidepressant

1st Line	• Switch to an agent with evidence for superiority	• Duloxetine [Level 2] • Escitalopram [Level 1] • Milnacipran [Level 2] • Mirtazapine [Level 1] • Sertaline [Level 1] • Venlafaxine [Level 1]
	• Add-on another agent	• Aripiprazole [Level 1] • Lithium [Level 1] • Olanzapine [Level 1]

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	Hong Kong Chinese (n=86)	Mainland Chinese (n=91)	Taiwan Chinese (n=86)	Korean (n=97)	Vietnamese (n=98)
Becoming more active physically	**20.9%**	**18.7%**	**19.8%**	**28.9%**	**28.6%**
Dealt with people with similar problems	9.3%	7.7%	9.3%	9.3%	7.1%
Getting out and about more	2.3%	2.2%	4.7%		4.1%
Talking with other people	10.5%	**18.7%**	**16.3%**	11.3%	2.0%
Attending courses on relaxation	8.1%	6.6%	9.3%		**16.3%**
Cutting out alcohol altogether					1.0%
Treatment from a traditional healer	2.3%	2.2%	1.2%		1.0%
Psychotherapy or counseling	**23.3%**	**26.4%**	**16.3%**	**24.7%**	7.1%
Taking a holiday	**14.0%**	12.1%	15.1%	**22.7%**	6.1%
Admitted to psychiatric hospital		1.1%	1.2%	1.0%	**8.2%**
Admitted to a psychiatric ward of a general hospital					1.0%
Acupuncture					1.0%
Special diet or avoiding certain foods					3.1%
Taking vitamins and minerals					2.0%
Taking psychiatric medicines	4.7%	1.1%	1.2%		4.1%
Taking some sleeping pills					1.0%
Taking pain relievers					2.0%
Other	4.7%	4.4%	5.8%	3.1%	4.1%

Table 13: Depression Vignette - the intervention considered to be the most helpful*

* some respondents chose more than one intervention as the "most helpful intervention"
** the three most popular choices of each group are bolded

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Beliefs about Western Medicine

- Nature of Western Medicine:
  - Too strong
  - Not pure or natural
  - Harmful for the body, especially long term
    - 藥有三分毒
  - Mask symptoms vs treat underlying disease
    - 治表不治本
- Self-Adjustment of Doses
- Acute vs Maintenance
- Conflicting CAM Beliefs

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LEARN MODEL

- ◆*L* LISTEN
- ◆*E* EXPLAIN
- ◆*A* ACKNOWLEDGE
- ◆*R* RECOMMEND
- ◆*N* NEGOTIATE

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Table 2
Summary of recommendations for physical therapies.

Therapy	Indication	Evidence	Recommendation	Comment
Light	Seasonal (winter) MDD	Level 1	First-line	Monotherapy
	MDD (mild-moderate severity)	Level 2	Second-line	Adjunctive therapy
Sleep deprivation	MDD (mild-moderate severity)	Level 2	Third-line	Adjunctive therapy
	Seasonal (winter) MDD	Level 2	Third-line	Adjunctive therapy
	MDD in pregnancy or postpartum	Level 2	Third-line	Adjunctive therapy
Exercise	MDD (mild-moderate severity)	Level 2	Second-line	Adjunctive therapy
Yoga	MDD (mild-moderate severity)	Level 2	Second-line	Adjunctive therapy
Acupuncture	MDD	Insufficient evidence for recommendation		

Note: Much of the evidence for physical therapies is limited by small sample sizes, problems with blinding, and short durations. Unlike pharmaceutical agents or evidence-based psychotherapies, in most countries there is limited standardization of physical therapies and practices. Clinicians must be aware that techniques of practitioners may not reflect those used in clinical studies

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Psychotherapy

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Common Psychotherapies for Depression and Anxiety

- Cognitive Behavioral Therapy
- Interpersonal Psychotherapy
- Psychodynamic Psychotherapy

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Culture & Psychotherapy

- ►Cultural-embedded healing practices
  - Shamanism
- ►Culture-influenced psychotherapy
  - Morita Therapy
- ►Culture-related "common" psychotherapies

Tseng 2001

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- Goal
- Content
- Process

Lo and Fung, 2003

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Culture as a Reference Point

- Culturally reinforcing
- Culturally neutral
- Counter-cultural

Lo and Fung, 2003

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Cultural Analysis

- Self
  - Affect, Behaviour, Cognition
  - Aims / goals / motivation
  - Body
  - (Self-) Concept
- Relations
- Treatment

Lo and Fung, 2003

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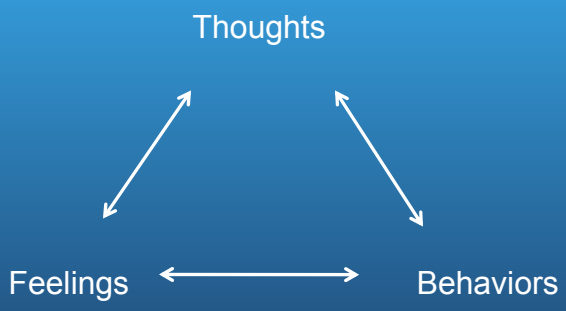
Cognitive Behavioral Therapy



Cognitive Model of Anxiety

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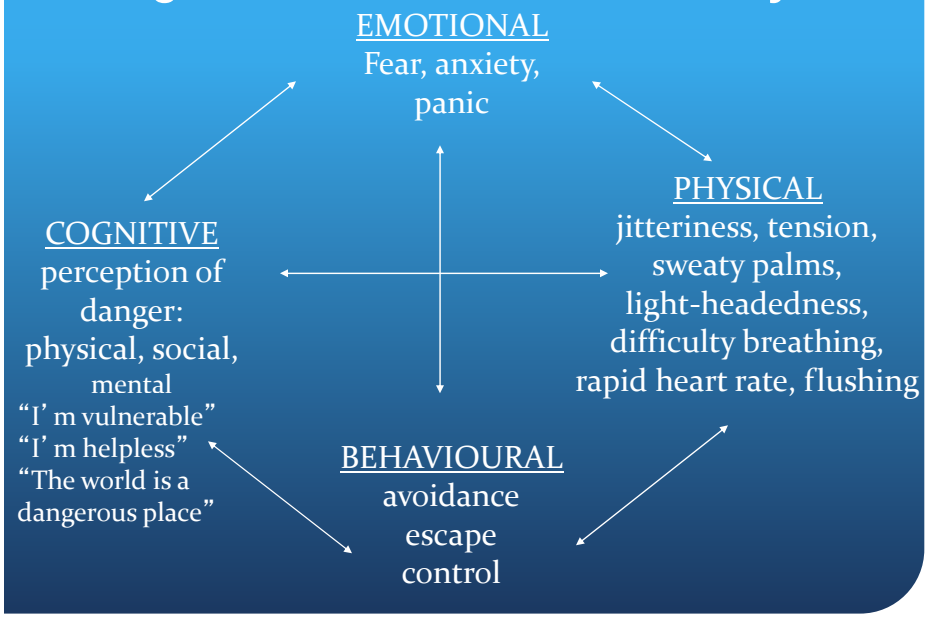

Common Cognitive Distortions

50

- *All-or-Nothing Thinking*
- *Overgeneralization*
- *Mental Filter*
- *Disqualifying the Positive*
- *Jumping to Conclusions*
- *Mind Reading*
- *Magnification and Minimization*
- *Emotional Reasoning*
- *Should Statements*
- *Labeling and Mislabeling*
- *Personalization*

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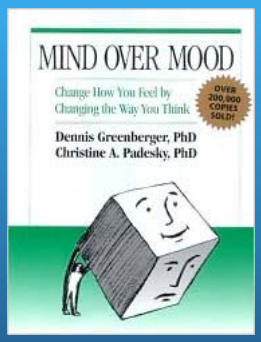

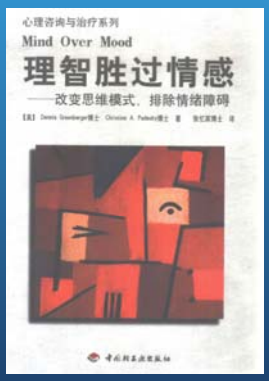

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CBT & Chinese

Cultural compatibility:
- More directive therapist
- Clear structure in therapy
- Spirit of self-improvement, and akin to conventional learning esp in structured groups
- Rational
- Beliefs in positive thoughts, Ah-Q (阿Q)

Challenges:
- Accessing automatic thoughts may be difficult
- Homework can be a problem
- Collectivism: values and interdependent self
- Beliefs of Fate, Bad Luck, Yuen Fan, etc.

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CBT in Hong Kong Chinese

TABLE 2. Effect sizes of the C-BDI, COPE, DAS, negative emotions, and positive emotions when comparing the post-test scores of the experimental and control groups

	Cohen's *d*
C-BDI	0.76
COPE	0.57
DAS	0.88
	0.13
	0.59

epression Inventory; DAS,

TABLE 4. Predictors of the C-BDI for the experimental group

Predictors	β	*SE*	*t*	*P*
COPE	−0.13	0.53	−0.11	0.91
DAS	0.25	0.14	2.457	0.01**
Positive emotions	−0.11	0.07	−0.918	0.364
Negative emotions	0.26	0.04	1.95	0.07

**$P<0.01$.
C-BDI, Chinese version of the Beck Depression Inventory; DAS, Dysfunctional Attitude Scale.

Wong, 2008

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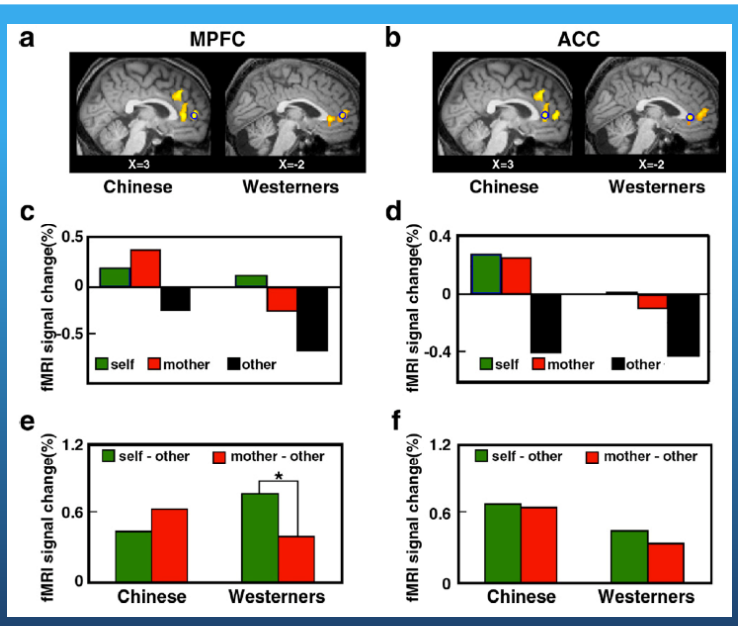

Zhu et al, 2007

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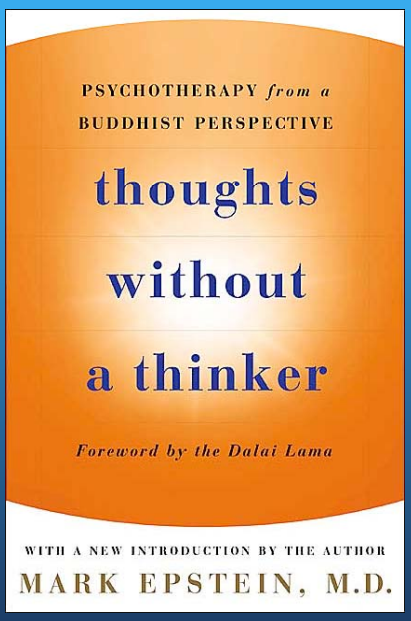

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Evolution of Psychological Interventions

- "1st Wave"
  - Behavioral Therapy
- "2nd Wave"
  - Cognitive Behavioral Therapy
- "3rd Wave"
  - Acceptance and Commitment Therapy
  - Dialectical Behavioral Therapy
  - Mindfulness-Based Cognitive Therapy

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The Primary ACT Model of Treatment

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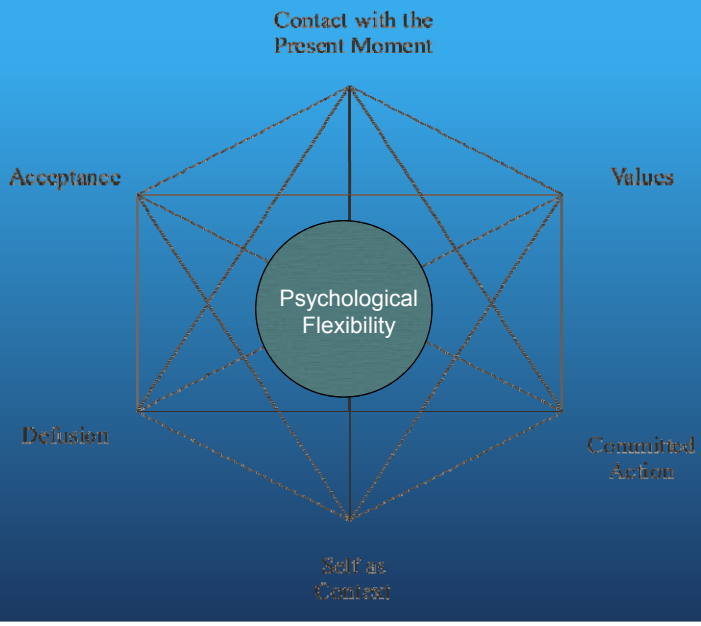

Four Noble Truths in Buddhism

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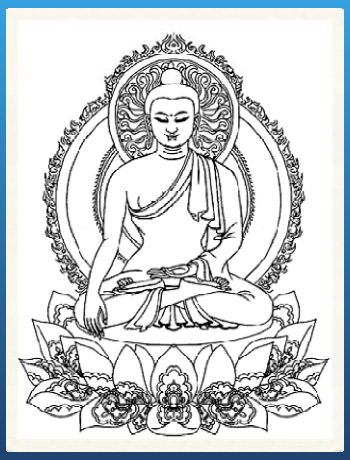
- *Dukkha*: There is suffering. Suffering is an intrinsic part of life - experienced as dissatisfaction, discontent, unhappiness, impermanence.
- *Samudaya*: There is a cause of suffering, which is attachment and desire (*tanha*).
- *Nirodha*: There is a way out of suffering, which is to eliminate attachment and desire.
- *Magga*: The path that leads out of suffering is called the Noble Eightfold Path.



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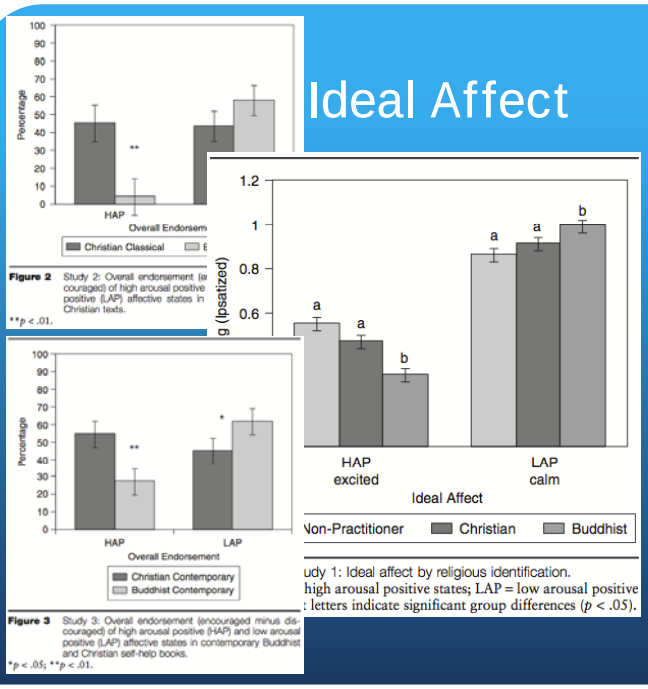
Ideal Affect



Tsai et al, 2007

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Ideal Affect

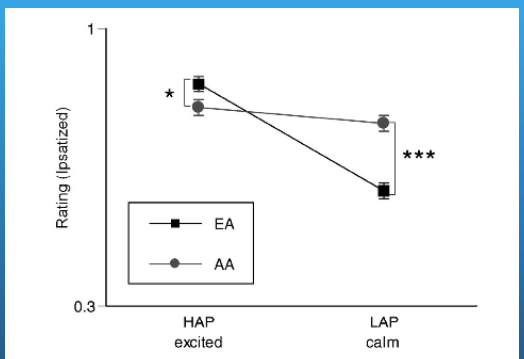

Figure 2. Group differences in ideal high-arousal positive states (HAP) and low-arousal positive states (LAP) (ipsatized mean and standard error), controlling for actual affect, in Study 1. EA = European American group; AA = Asian American group. *$p < .05$. ***$p < .001$.

Tsai et al, 2006

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