

## **Chinese Taoist Cognitive Psychotherapy in the Treatment of Generalized Anxiety Disorder in Contemporary China**

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**Abstract** Chinese Taoist cognitive psychotherapy (CTCP) combines elements of cognitive therapy and Taoist philosophy. Empirical evidence of its efficacy and mechanisms of action is lacking. This study compared the efficacy of CTCP, benzodiazepines (BDZ), and combined treatment in Chinese patients with generalized anxiety disorder (GAD). In total, 143 patients with GAD were randomly assigned to one of three treatment groups: CTCP only, BDZ only, or combined CTCP and BDZ treatment. Patients were evaluated at intake, and re-examined one and six months after treatment. The results indicated that BDZ treatment rapidly reduced symptoms of GAD at one month, but its effect was lost at six months. CTCP reduced symptoms more slowly and its effect was significant after six months of treatment. Combined treatment led to acute, as well as enduring, symptom reduction. Unlike BDZ treatment, CTCP reduced type A behavior, improved coping style, and decreased neuroticism. It is concluded that CTCP with or without BDZ treatment is a more effective, although slower, method for the treatment of GAD than BDZ for GAD patients in urban China.

**Key words** anxiety • China • Chinese • psychotherapy • Taoist

As a result of rapid economic reforms and social transformations, China has witnessed rising rates of a similar constellation of mental and social health problems as the West, including mood disorders and high rates of suicide (Lee & Kleinman, 1997). However, psychotherapy is extremely limited in the country, while the disciplines of clinical psychology and psychiatric social work have barely evolved. In addition, because the rationales of the commonly known psychotherapies are based on such western values as individuation, self-control, and self-efficacy, continued controversies exist as to whether such 'western products' work in the Chinese context (Cheng, 1993; Tseng, 1999; Young, 1996). As a consequence of the growing influence of western psychiatric theories and practices, some urban Chinese psychiatrists have sought to blend empirically validated forms of psychotherapies, especially cognitive therapy (Durham et al., 1999), with aspects of Chinese culture that may be therapeutically useful (Ji, 1994). However, owing to the limitation of resources for research, empirical studies of such treatment methods can only be carried out at elitist academic centers, and are rarely reported in the English language literature.

Construction of the theories, objectives, and methods of practice of a psychotherapy is profoundly influenced by the socio-cultural context from which it emerges. In this respect, Confucianism and Taoism must be relevant to the development of Chinese psychotherapies because they have permeated practically every aspect of Chinese people's psychological, social, and moral life for thousands of years. Confucianism emphasizes

hierarchy, moral development, achievement, and social responsibility. Excessive compliance with it may give rise to rigidity, feelings of being challenged by responsibility, and frustration. In contrast, Taoism focuses on conforming to natural laws, letting go of excessive control, and the flexible development of personality. Extreme adherence may foster passive compromise, resignation, and apathy (Zhang & Young, 1998).

Confucianism and Taoism are best seen as complementary opposites of indigenous psychology. Although Chinese people appear Confucianist in public, they employ Taoist defenses as a means of thought control and coping (Zhang & Young, 1997). Since the perception of stressors is influenced by values, and the choice of coping methods in turn depends on one's value system, it is intuitively plausible that blending Confucian and Taoist values with psychotherapeutic skills may expedite psychological change during psychotherapy. Based on years of clinical experience, we have found that Taoist values are helpful to patients with anxiety disorders, which represent the most common form of mood disorders in Chinese community epidemiological as well as clinical studies (Lee & Kleinman, 1997). Since anxiety disorders are widely treated with benzodiazepines (BDZ) by both psychiatric and non-psychiatric doctors in China, the empirical elucidation of a locally applicable form of psychotherapy is of special importance. We have developed what we call 'Chinese Taoist cognitive psychotherapy' (CTCP), which shares broad principles with cognitive therapy. The essential procedures are summarized in the Appendix to this article according to the acronym ABCDE (Zhang & Young, 1998). The goal of CTCP is to regulate patients' negative affect, correct maladaptive behavior, and prevent mental illness by changing personal modes of thinking and styles of coping.

## Method

### *Study Groups*

From the Hunan, Shanghai, Zhejiang, and Daqin Mental Health Centers, a total of 143 patients with generalized anxiety disorder (GAD), diagnosed according to the Second Revision of the Chinese Classification of Mental Disorders (CCMD-2-R), participated in this study (Chinese Medical Association and Nanjing Medical University, 1995). These CCMD-2-R criteria for GAD were basically the same as those of the ICD-10 and DSM-IV, except that the condition had a duration criterion of three months rather than six months (Lee, 1996). All patients were not in psychiatric treatment prior to the study. They gave written informed consent.

### *Treatment*

Patients were randomly assigned to one of three treatment groups: (i) CTCP only, (ii) BDZ treatment only, and (iii) combined CTCP and drug treatment. Drug treatment consisted of variable doses of an oral BDZ, such as diazepam and alprazolam, administered according to patients' clinical condition (dose range was 10–20 mg diazepam equivalent). CTCP was carried out by the first author and three other experienced psychiatrists trained in this treatment method.

### *Study Procedures*

The study lasted six months and consisted of two phases. The first phase consisted of one month of weekly sessions, while the second phase was composed of five months of twice monthly sessions. For the CTCP only and combined treatment groups, each session lasted an hour. For the BDZ only group, each session lasted about 10 minutes. Drug dosage was unaltered after the first phase. All patients completed baseline psychometric evaluations and were reassessed after one and six months of outpatient treatment respectively.

### *Measures*

Outcome measures were Chinese versions of the Symptom Checklist (SCL-90) (Derogatis, 1977), Type A Personality Scale (Friedman & Rosenman, 1959), Eysenck Personality Questionnaire (EPQ) (Eysenck & Eysenck, 1975), and Coping Style Questionnaire (Zhang, 1993). The EPQ was not administered at one month as personality change was unlikely to occur after such a short period.

### *Data Analysis*

Statistical analysis was performed with SPSS. Chi-square tests were used to compare categorical variables between groups, and repeated measures ANOVA were used to compare continuous variables over time. The level of statistical significance was set at .05. All tests were two-tailed.

## **Results**

### *Demographic Characteristics*

The three groups of patients exhibited no significant difference in gender distribution, age, education, marital status, and duration of illness (Table 1). No patient dropped out at one month, but subsequently 3 (6.5%), 6

**TABLE 1**  
Demographic characteristics of patients in the three treatment groups

Variable	CTCP (N = 46)		Drug (N = 48)		Combined (N = 49)		p
	n	%	n	%	n	%	
Gender							ns
Male	28	60.9	23	47.9	29	59.1	
Female	18	39.1	25	52.1	20	40.9	
Education							ns
Primary	6	13.1	5	10.5	5	10.2	
High school	26	56.5	33	68.7	29	59.1	
College	14	30.4	10	20.8	15	30.7	
Marital status							ns
Single	18	39.1	16	33.3	12	24.5	
Married	28	60.9	30	62.5	36	73.4	
Divorced	0	0	2	4.2	1	2.1	
	<i>mean</i>	<i>SD</i>	<i>mean</i>	<i>SD</i>	<i>mean</i>	<i>SD</i>	
Age (years)	34.6	13.0	33.6	10.8	36.3	10.1	ns
Illness duration (years)	3.8	3.1	2.7	3.9	4.6	4.8	ns

(12.5%) and 4 (8.2%) patients dropped out from the CTCP, BDZ only and combined treatment groups respectively. GAD was moderately chronic in all study groups.

### Outcome Measures

There was no significant difference in SCL-90 scores among the three groups at intake. At one month, patients who received drug only or combined treatment reported significantly lower mean SCL-90 scores than the CTCP only group. There was no significant change in SCL-90 scores within the CTCP group at one month. However, at six months, groups receiving CTCP only or combined treatment reported significantly lower SCL-90 scores than the BDZ only group (Table 2). In contrast, the SCL-90 scores of the BDZ only group returned to near intake levels.

The BDZ only group exhibited no improvement in type A behavior throughout. In contrast, improvement was noticeable at six months and more significant in the CTCP only group than the combined treatment group (Table 3).

The Coping Style Questionnaire revealed that, compared with BDZ

**TABLE 2**  
Mean SCL-90 scores (range 0–360) at intake, after 1 month and 6 months of treatment

<i>Time of measure</i>	<i>1. CTCP</i>		<i>2. Drug</i>		<i>3. Combined</i>		<i>Between groups</i>
	<i>mean</i>	<i>SD</i>	<i>mean</i>	<i>SD</i>	<i>mean</i>	<i>SD</i>	<i>p</i>
a. intake	90.7	52.5	113.8	66.0	107.0	56.0	<i>ns</i>
b. 1-month	88.1	64.2	46.7	40.4	53.6	64.2	(1.2)(1.3)
c. 6-month	49.3	48.1	99.6	67.7	47.2	50.2	(1.2)(2.3)
<i>Across times</i>	<i>(a.c) (b.c)</i>		<i>(a.b) (b.c)</i>		<i>(a.b) (a.c)</i>		

*Note:* Letters or numbers in brackets indicated significant difference ( $p < 0.05$ ).

**TABLE 3**  
Scores on the Type A Personality Scale (range 0–60) at intake, after 1 month and 6 months of treatment

<i>Time of measure</i>	<i>1. CTCP</i>		<i>2. Drug</i>		<i>3. Combined</i>		<i>p</i>
	<i>mean</i>	<i>SD</i>	<i>mean</i>	<i>SD</i>	<i>mean</i>	<i>SD</i>	
<i>Time urgency</i>							
Intake	13.7	3.8	14.2	4.5	14.3	4.4	<i>ns</i>
1-month	12.8	4.4	14.3	4.4	13.3	4.3	(1.2)
6-month	9.6	3.1	14.1	4.2	10.4	4.6	(1.2)(2.3)
<i>Hostility</i>							
Intake	13.9	4.1	14.5	4.0	13.9	4.3	<i>ns</i>
1-month	12.3	3.7	13.3	3.9	12.6	4.3	<i>ns</i>
6-month	10.0	3.1	13.4	3.3	12.1	4.2	(1.2)(1.3)
<i>Total scores</i>							
Intake	27.6	6.5	28.7	7.6	28.2	8.0	<i>ns</i>
1-month	25.1	7.1	27.6	7.3	26.0	7.9	<i>ns</i>
6-month	19.6	5.1	27.4	6.4	22.6	7.8	(1.2)(2.3)(1.3)

*Note:* Numbers in brackets indicated significant difference ( $p < 0.05$ ).

treatment alone, patients receiving CTCP or combined treatment significantly decreased substance abuse (predominantly alcohol and nicotine) and increased their participation in recreational activities after six months (Table 4).

**TABLE 4**  
Coping style at intake, after 1 month and 6 months of treatment

Variable and time	1. CTCP		2. Drug		3. Combined		p
	mean	SD	mean	SD	mean	SD	
To suppress or deny							
Intake	1.7	0.6	1.7	0.8	1.8	0.7	ns
1-month	1.4	0.6	1.1	0.7	1.4	0.7	ns
6-month	1.1	0.5	1.3	0.7	1.4	0.7	ns
To express oneself openly							
Intake	1.2	0.6	1.4	0.8	1.3	0.7	ns
1-month	1.5	0.6	1.6	0.7	1.4	0.5	ns
6-month	1.7	0.5	1.6	0.6	1.5	0.6	ns
To sublimate							
Intake	0.7	0.7	0.6	0.7	0.7	0.6	ns
1-month	1.0	0.7	0.7	0.7	0.8	0.7	ns
6-month	1.2	0.5	1.0	0.7	1.0	0.6	ns
To abuse substances							
Intake	0.6	0.6	0.6	0.7	0.5	0.7	ns
1-month	0.4	0.5	0.4	0.7	0.4	0.6	ns
6-month	0.1	0.3	0.4	0.5	0.1	0.3	(1.2)(3.2)
To punish oneself							
Intake	0.8	0.5	0.8	0.7	0.6	0.7	ns
1-month	0.4	0.6	0.5	0.6	0.3	0.6	ns
6-month	0.3	0.6	0.5	0.7	0.2	0.6	ns
To vent							
Intake	1.5	0.7	1.2	0.8	1.1	0.8	ns
1-month	1.1	0.5	1.1	0.7	1.0	0.7	ns
6-month	1.0	0.5	1.3	0.7	1.1	0.5	ns
To withdraw and console oneself							
Intake	0.9	0.6	0.6	0.7	0.6	0.5	ns
1-month	0.9	0.7	0.6	0.8	0.6	0.8	ns
6-month	1.0	0.6	0.7	0.7	0.7	0.8	ns
To engage in recreational activities							
Intake	1.1	0.5	0.9	0.7	1.2	0.8	ns
1-month	1.3	0.6	1.1	0.7	1.2	0.7	ns
6-month	1.7	0.6	1.1	0.6	1.7	0.6	(1.2)(3.2)

Note: Letters or numbers in brackets indicated significant difference ( $p < 0.05$ ).

On the EPQ, the CTCP only group demonstrated a significantly lower level of neuroticism than the BDZ only group after six months. This difference was not seen in the combined treatment group (Table 5).

### Discussion

This preliminary study has a number of limitations, some of which provide leads for further research. Nonetheless, because the field of psychotherapy has been gravely under-served in China, we believe that the findings are worth reporting. First, owing to the limited resources available at any one center, our case identification and treatment were not well standardized. Second, because we did not include blind ratings of a group of patients who received a standard form of psychotherapy, we cannot compare the efficacy of CTCP with other forms of therapy. Third, we do not have long-term data to show whether the positive personality changes brought about by CTCP are maintained after treatment was terminated, or when BDZ was taken off in the combination treatment group of patients. Fourth, there was no evaluation of patients' medication compliance, so it remained possible that the attenuation of drug effect was due to non-compliance, especially in the BDZ only group compared with the combination treatment group. However, our clinical experience suggests that non-compliance with BDZ was uncommon. Instead, there was a tendency for

**TABLE 5**  
EPQ scores at intake, after 1 month and 6 months of treatment

Variable and time	1. CTCP		2. Drug		3. Combined		<i>p</i>
	mean	SD	mean	SD	mean	SD	
Extroversion (0–21)							
Intake	7.7	5.1	9.7	3.7	9.2	3.9	<i>ns</i>
6-month	9.1	5.7	10.2	3.5	10.2	3.5	<i>ns</i>
Neuroticism (0–23)							
Intake	14.6	4.3	14.1	4.7	14.6	4.5	<i>ns</i>
6-month	10.5	4.7	12.6	4.9	11.0	4.5	(1.2)
Psychoticism (0–25)							
Intake	7.4	3.3	8.6	3.6	7.5	3.7	<i>ns</i>
6-month	7.3	4.1	8.7	3.8	7.8	4.1	<i>ns</i>
Lie (0–21)							
Intake	11.9	3.9	10.9	3.7	11.3	3.3	<i>ns</i>
6-month	11.6	4.0	11.2	3.3	10.7	3.0	<i>ns</i>

Note: Letters or numbers in brackets indicated significant difference ( $p < 0.05$ ).



some patients to require higher drug dosage, though this was not entertained during the second phase of the study. Fifth, we did not measure changes in patients' value systems (i.e., Confucian vs. Taoist) in order to find out whether the therapeutic effect of CTCP was specifically mediated by such changes. Sixth, the reliability and validity of the Type A Personality Scale and the Coping Style Questionnaire require further study in China. Seventh, because CTCP was distinctly embedded in Taoist values, it would be useful to study how therapists' value orientations may influence treatment outcome. Finally, the patient drop-out rate was low by western standards, and could have been due to high motivation that followed pre-screening, or some unknown cultural factors.

Cognitive therapy is well established to be more effective than placebo or supportive psychotherapy in the treatment of anxiety disorders (Chambless & Gillis, 1993). Unlike BDZ treatment, the gains that are achieved in treatment are maintained at follow-up (Clark, 1995). The present study indicated that BDZ treatment was more effective than CTCP in the acute reduction of GAD symptoms. However, its effect became insignificant at six months, whereas CTCP became clearly superior. According to a meta-analysis of 35 controlled trials, both cognitive behavioral therapy and pharmacotherapy for GAD were effective in the short-term (Gould, Otto, Pollack, & Yap, 1997). However, the former was associated with clear maintenance of treatment gains, whereas the long-term efficacy of drug treatment was attenuated following medication discontinuation. Although we confirmed the established finding that the combination of CTCP with BDZ led to symptom reduction in both the short-term and the long-term (Schweizer & Rickels, 1996), whether our patients on combined treatment could be weaned off drugs after six months remained uncertain.

Since access to psychotherapy is extremely limited in China, patients are usually prescribed anti-anxiety medications. Despite the risks of dependence, tolerance, withdrawal, and relapse (Schweizer & Rickels, 1996), the chronic use of BDZs for anxiety disorders is widespread. From this vantage point, it is worth noting that CTCP did not merely reduce anxiety symptoms. At the six-month evaluation, it was associated with positive changes in type A behavior (primarily time urgency) and coping style that were not witnessed in the BDZ treatment only group. To a lesser extent, these effects were also seen in the combined treatment group. It is notable that CTCP was also effective in lowering neuroticism scores. Like cognitive therapy in the treatment of mood disorders, CTCP probably acts via multiple interactive mechanisms of thought control such as monitoring of negative thoughts, Socratic questioning, re-attributions, and homework (Marks & Dar, 2000). If this reduction of neurotic trait via cognitive restructuring was partly responsible for our patients' improvement during

CTCP, then the slower mode of action of CTCP relative to BDZ treatment might be explained. Given that personality difficulties contribute to the chronicity of GAD (Yonkers, Dyck, Warshaw, & Keller, 2000) and core Taoist values such as letting go of excessive control are also useful for Western patients with neurotic disorders (Shapiro, 1998), future studies can explore the value of CTCP, in whatever way it is labeled, in different cultural contexts.

Tseng (1999) concluded that for a western psychotherapy to be culture-relevant in a non-western setting, certain technical adjustments, theoretical modifications, and philosophical reorientation would be required. Empirical evidence on how such modifications can be made are, however, mostly lacking in the Chinese context. The first of its kind, the present study furnishes evidence that a psychotherapy that was primarily cognitive in approach and included indigenous Taoist values was effective in Chinese patients with GAD. This casts doubt on the still popular notion that Chinese patients somatize their emotions, are not psychologically minded, and distrust 'talk therapy' (Lee, 1998). Although teaching the Taoist 32-character formula might sound like indoctrination, the approach appeared to be accepted by patients in this study.

There may be cultural reasons why Chinese patients are inclined to accept a more didactic form of psychotherapy. Like other collectivistic Asian cultures, Chinese culture in China is highly hierarchical in organization. Its social and political institutions are permeated by the values of authority dependence, harmony, and compliance (Hsu, 1970). As Cheng (1993) in Hong Kong pointed out, we found that patients frequently asked for explanations and instructions rather than sought self-exploration during the course of psychological treatment. Even in Shanghai, arguably the most cosmopolitan and westernized city in China, Ji (1994) maintained that 'good will' (or paternalism in the western sense) and 'active persuasion' were important elements of successful psychotherapy and communication in general. In this respect, it is worth noting that during the Cultural Revolution (1966–1976), state-imposed 'thought reform' (debatably a form of 'cognitive' intervention) through repetitious Communist Party meetings ostensibly transformed the mind set of millions of people over and above filial and other traditional values that had governed the behavior of Chinese people for thousands of years (Lee, 1999).

It is perhaps not surprising that the most common form of psychotherapy practised in China nowadays is cognitive and often directive in approach. Psychoanalytic and psychodynamic therapies are virtually nonexistent. In this connection, Durham and coworkers (1994) demonstrated that cognitive therapy was not only more effective than analytic therapy in the treatment of GAD, but was also easily learned by junior psychiatric doctors after brief instruction in behaviorally based anxiety management.

Given that the discipline of clinical psychology has hardly evolved and there are very few experienced or full-time psychotherapists in China, the clear procedures of CTCP may make it easier for trainee psychiatrists in different regions of China to learn than the analytic therapies. Attracting more doctors into the domain of psychotherapy will also constitute a timely counter force to the overwhelming pharmacological approach to the treatment of mood disorders in China nowadays (Lee, 1999). Future studies of CTCP or other indigenous psychotherapies should include a comparison group of patients on other forms of psychotherapies, blind ratings, and other mood disorders such as depression.

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## Appendix

### *Summary of the 'ABCDE' of Chinese Taoist Cognitive Psychotherapy*

A. *Actual stress factors.* This assists the patient in identifying and analyzing the actual stressors connected with their illness. The evaluation of stressors is based primarily on subjective experience rather than the objective number of stressful events. A self-rated Life Events Scale (Zhang & Young, 1992) is used in addition to qualitative evaluation.

B. *Belief and value system.* An individual's cognitive evaluation of an event plays an important role in mediating stressors and determining subsequent emotions and behavior. The cognitive set is in turn dependent on his/her values. It follows that change of values will transform emotions

and behaviors. Typically, an individual has multiple needs organized according to his/her value systems. This hierarchy of needs is referred to as the belief system. In eliciting this belief system, care should be taken to instruct the patient to base the hierarchy on personal opinion rather than popular moral principles. The patient is provided with a list of 10 common needs (namely, money, freedom, love, position, health, power, fame, friendship, family, and enjoyment). He/she selects the most important need, which is assigned a score of 10 points. Next, the least important need is assigned a score of 1 point. Each subsequent item may then be ordered between these two scores.

C. *Conflict and coping style.* Based on the evaluation of actual stressors and belief system, this stage analyzes the patient's psychological conflicts and his/her coping style. Since objective reality is such that an individual's needs are never completely met, one either has to change reality or abandon some of one's desires. If neither of these is feasible, psychological conflicts will arise and the individual has to resort to coping strategies. There are eight common styles of coping used by people in modern China: (1) to suppress or deny, (2) to express oneself openly, (3) to sublimate, (4) to abuse substances, (5) to vent, (6) to punish oneself, (7) to withdraw and console oneself, and (8) to engage in recreational activities (Zhang, 1993). The patient is presented with these styles and asked to indicate the degree to which they employ each of them (i.e., never, seldom, sometimes, often, always). The relative usefulness of these coping methods is discussed.

D. *Doctrine direction and practice.* This is the therapeutic core of the CTCP. After the complementary roles of Taoism and Confucianism are explained, the 32-character Taoist formula is interpreted word for word for the patient in the hope that its spirit is assimilated in the context of his/her psychological conflicts and coping styles (Lao, 1986; Zhang & Young, 1998; Zhuang, 1986). The first eight characters comprise the sentence '*li er bu hai, wei er bu zheng*'. This item comes from Chapter 22 in *Lao-zi*. It is interpreted as benefiting without hurting others and acting without striving. The second set of eight characters comprises the sentence '*shao si gua yu, zhi zu zhi zhi*'. This principle comes from Chapters 41, 43, and 46 in *Lao-zi* and *Zhuang-zi Xiao yao you*. It involves restricting selfish desires, learning to be content, and knowing how to let go. The third set of eight makes up the sentence '*zhi he chu xia, yi rou sheng gang*'. This item comes from Chapters 41, 43, and 78 in *Lao-zi*. It is interpreted as being in harmony with others and being humble, using softness to defeat hardness. The fourth set of eight characters forms the sentence '*qing jing wu wei, ren qi zi ran*'. This sentence is the central thought of Taoism. It suggests that a person should maintain tranquillity, act less, and follow the laws of nature. The patient must grasp as well as put the principles into practice in daily

life. A diary of experience is kept and is used to re-discuss the doctrine in the context of the patient's psychosocial difficulties.

E. *Effect evaluation and reinforcement.* A comprehensive assessment of effectiveness is conducted via the patient's self-report and clinical rating scales. The patient is asked to summarize and discuss his/her experience. The therapist encourages him/her to point out any setbacks and to strengthen the treatment effects.

*Note:* The five stages take about five hours to complete, and are flexibly divided into five sessions of one hour each. The stages, mostly D and E, are repeated after the first cycle is completed.

**8<sup>th</sup> Annual McGill Summer Program  
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May 6-31, 2002**

The Division of Social and Transcultural Psychiatry of McGill University will hold its Annual Summer Program in Montréal, Québec, Canada. Courses and workshops include: Cultural Psychiatry; Psychiatric Epidemiology; Clinical Methods in Cultural Psychiatry; Introduction to Qualitative Research Methods; Economic Evaluation in Psychiatry; and Participatory Community Research.

The 4<sup>th</sup> Annual Advanced Study Institute on the theme "Body, Memory and Identity" will be held from June 4-7, 2002, with international faculty.

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