

## **Letting a Hundred Flowers Bloom: Counseling and Psychotherapy in the People's Republic of China**

**Doris F. Chang**  
**Huiqi Tong**  
**Qijia Shi**  
**Qifeng Zeng**

*Although the Chinese have been exposed to Western psychotherapies since the 1950s, the practice of counseling is a relatively new phenomenon. In this article, we trace the development of counseling in China, examine its cultural and practical relevance, and review recent advances in training and practice. Although heavily influenced by Western models, contemporary Chinese approaches to counseling reflect the philosophical traditions, cultural history, and indigenous help-seeking practices of a rapidly modernizing society. The increasing popularization of psychotherapy in China is analyzed in the context of the changing social and economic climate and the crises and opportunities that accompany Chinese life in the 21st century.*

The past 50 years have witnessed China's remarkable transformation from a poor agricultural society into an emerging industrial power. With the opening-and-reform policies initiated in the 1980s, China has officially reentered the global fray, experimenting with Western ideas, markets, and institutions, including Western-style counseling and psychotherapy. In this article, we trace the development of counseling in China, examine its cultural and practical relevance, and review recent advances in training and practice.

The techniques of counseling and psychotherapy have found a home in China. However, their Western cultural origins have created problems in translation, not the least of which is their literal translation into the Chinese language. The Chinese use two terms to refer to what may be generally described as talk therapy: *xinli zixun* (i.e., psychological counseling or consulting) and *xinli zhilitiao* (i.e., psychotherapy). However, the cross-cultural correspondence of these constructs remains unclear. In practice, *xinli zixun* encompasses a variety of counseling services, including informal supportive

---

*Doris F. Chang, Ph.D., is with the Graduate Faculty of Political and Social Science, New School University, New York. Huiqi Tong, M.D., is with the Pacific Graduate School of Psychology, Palo Alto, CA. Qijia Shi, M.D., is with the Department of Neurology, Tong Ji Medical University, Wuhan, P.R. China. Qifeng Zeng, M.D., is with the Chinese-German Psychological Hospital, Wuhan, P.R. China. E-mail: changd@newschool.edu*

counseling, drop-in psychological consultation, psychoeducation, and psychotherapy. Furthermore, because academic degree programs in mental health counseling do not yet formally exist, the training and practice orientations of China's counseling professionals show considerable variation. It is important to note that this struggle for self-definition reflects the natural developmental progression in any emerging discipline from general practice to specialization. At present, the number of trained counselors remains small, necessitating role flexibility and interdisciplinary cooperation in order to advance the field (M. Li, personal communication, July 27, 2004).

If U.S. trends are any indication, we expect the boundaries between mental health counseling and psychotherapy to become more clearly delineated over time, perhaps followed by a return to more integrative approaches (Shi, Sang, Li, Zhou, & Wang, 2005). As the Chinese proverb reminds us, "Separation and integration inevitably occurs when either goes to the extreme." In this article, we use the terms *psychotherapy* and *counseling* interchangeably to reflect the fluid definitions of these emerging professional arenas in China today.

#### **A BRIEF HISTORY OF PSYCHOTHERAPY AND COUNSELING IN CHINA**

Although indigenous forms of psychotherapy have arguably existed in China for centuries, what is commonly referred to as psychotherapy today has evolved out of the country's political and academic relationships with the West. From the founding of the People's Republic of China in 1949 to the present, the development of psychotherapy may be divided into four stages. From 1949 to 1969, Chinese psychiatry was heavily influenced by Russian neuropsychiatric models with political priorities focused on maintaining public order (Qian, Smith, Chen, & Xia, 2001). In the era of the Cultural Revolution, 1966-1977, mental illness and other forms of deviance were cast as problems of wrong political thinking to be addressed through reeducation, rather than mental health care (Pearson, 1995). Political and economic reforms initiated in the years between 1978 and 1986 facilitated the revitalization of Chinese psychiatry and its reengagement with Western scientific communities. National professional meetings and international exchanges were initiated, clinical research resumed, and new periodicals and professional journals were founded (Qian et al.).

The fourth stage, from 1987 to the present, has witnessed a blossoming of the mental health field in China. This growth has been fueled by the government's recent acknowledgment of the social burden caused by mental health problems and a variety of state-sponsored initiatives to improve access to psychological services in the country's hospitals, schools, and prisons. The first professional psychological clinic was established in Kunming in 1994. Today,

mental health clinics have been established in most major cities, and psychological counseling and psychotherapy services are widely available in urban hospitals. The late 1980s marked the establishment of the German-Chinese Psychotherapy Training Program, which is widely acknowledged as the most rigorous psychotherapy training program in China today. Funded by public and private donors in Germany and China and cofounded by the Medical University of Kunming, the University of Beijing, Shanghai Mental Health Center, the Tongji University of Wuhan, and the West China University of Chengdu, the training program has helped to popularize the techniques of behavior therapy, hypnotherapy, psychoanalytic therapy, and systemic family therapy.

In large urban areas, counseling is now available in general hospital settings, mental health clinics, private practices, prisons, and schools, much like in the United States. Programs in psychosomatic medicine and consultation-liaison psychiatry are gradually being implemented in larger hospitals. In mental health clinics, counseling and therapy are being provided in outpatient, inpatient, and day treatment settings. A recent report released by the Ministry of Justice estimated that counseling has been conducted in more than 60% of Chinese prisons. And in September 2002, in response to the high rates of psychological disturbances identified in primary and secondary schools, the Ministry of Education called on all schools across the country to establish on-site psychological consulting rooms.

In summary, although the Chinese have been exposed to Western psychotherapies since the 1950s, the practice of psychotherapy and counseling is a relatively new phenomenon. Despite the dramatic improvements in the quality of life, the iatrogenic effects of social and economic reforms include heightened work and domestic tensions, rising rates of gambling, substance use and abuse, weakening of communal support networks, and increasing competition in the workplace (Guo, 1987; Phillips, Liu, & Zhang, 1999). In 1999, the Ministry of Public Health estimated the number of severely mentally ill at 16 million, with even higher numbers experiencing psychosocial problems and functional disability.

The demand for mental health services is also on the rise, as evidenced by the increased utilization of both outpatient psychiatric and mental health counseling services and the tremendous popularity of hot lines and radio call-in programs. By 2001, the Shanghai Mental Health Centre was providing psychological counseling to an average of 120 patients each day, a 60% increase from a decade before (Min, 2001). The most common reasons for seeking help were school-related problems, family/relationship difficulties, mental distress, and insomnia. Financial worries and anxiety about adapting to the changing demands of the marketplace also have been identified as key concerns for many Chinese (Chang, 2001).

### COUNSELING THE CHINESE CLIENT: PROCESS AND STRUCTURE

The escalating demand for counseling services in modern Chinese cities such as Beijing, Shanghai, and Wuhan appears to contradict popular descriptions of the Chinese as unwilling to disclose personal information to strangers, being prone to psychosomatic presentations and more comfortable with authoritarian, structured interactions with health-care providers, and preferring medical solutions to their problems (Lee, 1998). Moreover, because the goals of Western psychotherapy center on individuation, self-efficacy, and self-actualization, many Chinese professionals have questioned whether such Western cultural products can actually work in the Chinese context (Pearson, 1999; Young, 1996). Indeed, the finding that Chinese in the United States underutilize mainstream mental health services is attributed in part to the supposed mismatch between Western therapy styles and Chinese help-seeking preferences.

To what then can we attribute the growing interest in psychological interventions among contemporary Chinese? In exploring this question, it is important to acknowledge the extent to which mental health counseling in China is a unique cultural hybrid that differs from its American counterpart in subtle ways. In translation to the Chinese context, Western theories and techniques have been naturally "sinocized," that is, rendering them more familiar and more acceptable to Chinese sensibilities. The same is not true for American Chinese navigating the mainstream U.S. mental health care system.

With this in mind, there are a number of reasons why psychological interventions may be gaining in popularity. First, unlike the negative associations attached to psychiatric treatment, mental health counseling is more commonly viewed as a healing system for the masses. This new development is likely due to a variety of factors including the public's increased exposure to Western styles of expressing and coping with distress. For example, HBO's "The Sopranos," which provides one of the most complex and honest depictions of the dynamics of therapy ever seen on television, has been popularized in China along with "Sex and the City" through swift sales of pirated DVDs (O'Neill, 2004). Another factor is government-sponsored public education campaigns designed to reduce the stigma of mental illness (Kou, 1998; "Psychological consulting on the increase," 1995). The valued cultural icons of the teacher, mentor, and sage provide a convenient template for the contemporary Chinese therapist-counselor, who acts as moral guide and also stands as an emblem of modernity. Psychoanalysis in particular has become fashionable among wealthy, style-conscious urban consumers.

Second, the structure and process of Chinese counseling and therapy have evolved out of a more accepted medical model of treatment. As such, both clients and counselors operate under many of the same cultural scripts that

structure the medical encounter. Clients expect the counselor to demonstrate his or her clinical expertise by prescribing medication and providing explicit instructions for solving problems (Bond & Hwang, 1986). The notion of the therapeutic relationship and the regular scheduling of sessions are incongruous with Chinese representations of the expert healer who can produce speedy results. Counselors themselves also are socialized to take on an active, authoritarian role by providing guidance and direction.

Given the preference for short-term, problem-focused, and directive approaches to treatment, the psychological consultation model has proven to be a successful cultural adaptation. This model of service delivery, common in general outpatient hospital settings, takes the form of brief, 10-to-20-minute, drop-in appointments. Sessions are problem focused and may involve direct advice, psychoeducation, supportive listening, and medication prescription. The assessment phase is brief, follow-up appointments are not scheduled, and an ongoing relationship does not develop with the counselor. The goal is symptom removal rather than personal growth. (With regard to its time frame and pragmatic focus, the psychological consultation model bears some resemblance to deShazer and Berg's [1986] solution-focused brief therapy. Unfortunately, due to the scarcity of published articles that describe the specific techniques and theoretical components of the Chinese consultation model, it is premature to draw any formal comparisons between the two approaches at this time. The general strategies described in this article come largely from anecdotal evidence provided by our Chinese colleagues, many of whom are in the process of developing more structured models for counseling Chinese clients.)

A third possible reason for the growing interest in counseling services is that given its short-term nature, counseling remains relatively affordable for many Chinese. In many settings, the price of a 10-to-15-minute counseling/consultation session costs less than US\$5. Nonetheless, counseling services are still an extravagance for many in a country where the average per capita income remains below US\$1,000. In contrast, some psychoanalysts are able to collect as much as US\$12 per session, with services geared to a wealthier clientele.

A recent survey of individuals presenting at the psychosomatic medicine and psychotherapy outpatient service at Wuhan Tongji Hospital between 1999 and 2002 provides a window on counseling as it is practiced in clinical settings (Shi et al., 2005). Among the 195 valid questionnaires, 88 were from males and 107 were from females. The most common International Classification of Diseases diagnoses were anxiety disorders (33.3%), followed by depressive disorders (30.3%), schizophrenia (12.8%), hypochondriasis (2.1%), and personality disorders (2.1%). The vast majority (66.2%) received

only one session of therapy, 8.6% received two sessions, 3.0% received three sessions, and only 6.6% received four or more sessions of therapy. Those who discontinued therapy after only one or two sessions cited a variety of reasons, including rapid symptom relief brought about by a combination of psychotherapy and medication as well as scheduling conflicts and financial constraints that prohibited ongoing treatment. Patients with more severe disorders such as schizophrenia were referred for in-patient treatment (Shi et al.). The short-term, problem-focused, and directive approach to psychological counseling/consultation is just one example of how cultural modifications of Western models have made psychological treatments more accessible to the average Chinese. In yet another example of how Western structures of therapy are being reworked, a recent news article described a prison in Hangzhou where “prisoners seeking psychotherapy can first vent their rage ... by hitting a hanging sandbag and then go to another consultation room to talk with psychologists about their problems” (“Psychological clinics enter Chinese prisons,” 2002). Indeed, anecdotal evidence suggests that the structure of therapy may vary considerably across treatment settings. In areas of greatest economic growth and Westernization, the structure of service delivery more closely approximates what one might find in many clinics in the United States. At the Shanghai Mental Health Center, for example, many service providers are now emphasizing the importance of scheduling regular sessions to work on identified problems. The duration and number of sessions, the treatment plan, and the fee are discussed; the client also is socialized to view therapy as a unique kind of professional relationship.

The flexibility and creativity with which Western structures of therapy are being applied leads one to wonder to what extent specific theories have been intentionally or unintentionally modified to suit Chinese palates. After all, the act of translation is fundamentally an interpretive one, subject to cultural biases and limited by language and understanding. As Blowers (1994) pointed out, an early 1932 Chinese translation of Freud's (1900) *The Interpretation of Dreams* reinterpreted the sexual references or removed them completely. Among our Chinese colleagues, there is a general belief in the universality of human nature and cognition alongside the recognition that the Chinese social world produces unique manifestations of universal human experiences. However, given the lack of research studies of psychotherapy process and outcome, we can only begin to imagine the myriad ways in which the structure, theories, and techniques of Western psychotherapy are being interpreted and practiced by the scores of newly trained mental health counselors in China.

### RECENT DEVELOPMENTS IN PRACTICE

Between the years 1979 and 1992, the majority of psychotherapy-related publications in China focused on behavior therapy, cognitive therapy, and insight-oriented approaches with less published on biofeedback, supportive therapy, Morita therapy, music therapy, hypnosis, family therapy, and client-centered techniques (Zhong, 1992). A 1992 survey of 204 mental health professionals in China confirmed that the most common theoretical orientations were behaviorism, psychoanalysis, and cognitive therapy (Qian & Chen, 1998). However, in recent years, professional organizations such as the Chinese Counseling and Psychotherapy Association have encouraged psychotherapy integration as a means of capitalizing on the best that different approaches have to offer (Li, Duan, Ding, Yue, & Beitman, 1994).

Behavior therapy remains the most common approach, reflecting its early introduction into China and the relative ease with which it may be applied. A number of studies have documented the effectiveness of behavioral techniques in the treatment of hysteria (Zhang & Yang, 1986), obsessive-compulsive neurosis (Dong, Li, Tian, & Wen, 1980), phobia (Jia & Sun, 1995), and paraphilias (Fang, Li, & Sun, 1990). However, many of these studies are limited by their small sample sizes and lack of a control group.

Beck's model of cognitive therapy was introduced to the Chinese in 1989 by Ji and Xu in the influential *Chinese Journal of Mental Health*. Two international training programs on cognitive therapy were held in Shanghai in 1991 (Xu & Ji, 1996). In the 1990s, Junmian Xu developed a cognitive treatment model that was widely implemented across China. Standardized assessment procedures (i.e., Chinese SCL-90, Beck Depression Scale) were applied, followed by brief cognitive interventions. Sessions rarely exceeded 30 minutes and patients were seen on a walk-in basis. Sedatives or antidepressants were commonly prescribed as adjunctive treatments, along with Chinese medicinal herbs.

By 1996, 20 published studies had examined the efficacy of cognitive therapy for depression, anxiety disorders, sexual dysfunction, and personality disorders. In their review, Xu and Ji (1996) concluded that efficacy generally was confirmed. The successful application of cognitive and behavioral approaches to the Chinese patient has been attributed to their good cultural match with Chinese values of rationality and pragmatism, desire for guidance and prescription, and focus on symptom removal (Chen, 1995; Tung, 1984).

Asserting the influence of Taoism on Chinese cognitive and coping styles, Zhang and his colleagues (2002) developed the first indigenous form of cognitive therapy. Chinese Taoist Cognitive Psychotherapy (CTCP) involves a total of 15 1-hour sessions administered over 6 months. A careful assessment of the client's level of stress, hierarchy of needs, and conflict and coping styles

is followed by a discussion of the 32-character Taoist formula. As described by Zhang et al., the 32-character formula is composed of four eight-character sentences that outline the central tenets of Taoism: (a) “benefiting without hurting others, acting without striving”; (b) “restricting selfish desires, learning to be content, and knowing how to let go”; (c) “being in harmony with others and being humble, using softness to defeat hardness”; and (d) “maintain tranquility, act less, and follow the laws of nature” (p. 128).

Clients are helped to achieve a deep understanding of these philosophical tenets and to apply such principles as acceptance, detachment, tranquility, and conformity with the laws of nature as means of coping with psychosocial conflicts. Results of a randomized clinical trial involving 143 patients with generalized anxiety disorder support the efficacy of CTCP (Zhang et al., 2002). The most favorable outcomes were associated with a combination of CTCP and benzodiazepines, which led to significant symptom reduction among patients in both the short-term and long-term conditions.

Although theoretical articles on psychodynamic therapies have been common in China since the 1980s, insight-oriented approaches have been relatively slow to develop owing to cultural incongruities that have limited their appeal. First, whereas the behavioral and cognitive approaches intervene at the levels of behavior and thought, insight-oriented therapies emphasize the affective and the unconscious realms of human experience (Tung, 1991). This focus on one’s inner emotional life is in direct opposition to the value that many Chinese place on affective control (Wu, 1994). According to traditional Chinese medicine, a quiet mind contributes to the balance of *yin* and *yang*. Excessive emotion, desire, and self-indulgence are believed to adversely affect the body’s balance and may lead to the development of physical illness (Veith, 1997).

A second cultural incongruity has to do with the centrality of the client-therapist relationship in the analytic situation. Reflecting on her experiences working with Chinese Americans, Tung (1991) noted that the interdependent nature of the Chinese self and the emphasis on family relations diminishes the intensity of the therapeutic relationship and, therefore, the importance of the transference analysis. While therapy with Caucasians “deals mainly with transference distortions” (p. 192), Tung argued that for most Chinese-Americans, “therapeutic explorations are never far from the family sphere. The core conflict is worked out directly with the original cast of characters” (p. 192). Nevertheless, many practitioners assert that, with specific cultural modifications that take into account the extrapsychic, pragmatic, and rational orientation of many Chinese clients, psychodynamic and psychoanalytic approaches may be effectively applied (Wu, 1994; Yi, 1995).

Finding Freud’s emphasis on the family and early childhood experiences particularly relevant to the Chinese case, Beijing psychiatrist Zhong devel-

oped perhaps the first culturally modified version of psychodynamic therapy, which he termed *cognitive-insight therapy* (Qian et al., 2001; Zhong, 1988). A unique cultural feature of this short-term approach was its reliance on members of the larger family system to assist the client in recollecting salient childhood traumas (Tung, 1991). Case studies detailing the effective treatment of obsessive-compulsive behavior, phobias, and sexual paraphilias using cognitive-insight therapy have been published (Qian et al.). However, due to the difficulty in assessing treatment adherence, a randomized clinical trial of cognitive-insight therapy has yet to be conducted.

Over the past 10 years, psychoanalysis has begun making unexpected inroads into Chinese clinical practice. Under the auspices of the German-Chinese Psychotherapy Training Program, a few dozen of China's top psychiatrists have received training in psychoanalysis and other insight-oriented therapies. The first national psychoanalytic training program was initiated in 1997. Participants in the inaugural program received 10 days of intensive training and supervision from German analysts twice each year from 1997 to 1999. Three cohorts of psychiatrists have now completed the training curriculum as of September 2004. In 1996, the German-Chinese Continuing Education Program was created to provide advanced training and supervision to senior Chinese therapists to enable them to independently train practitioners in their own regions. At present, the field of psychoanalysis in China is in its infancy. We look forward to the presentation of research that critically examines its applicability to the Chinese context and contributes to the generation of culturally grounded theory and practice guidelines.

### TRAINING AND EDUCATION

Despite the growing interest in counseling in the urban areas, the supply of qualified mental health professionals is still exceedingly low, leading some to question the feasibility and cost-effectiveness of providing counseling at all (Pearson, 1999). Currently, there are fewer than 1,000 psychiatric institutions, 110,000 psychiatric beds, and 13,000 mental health professionals in all of China, with most resources concentrated in the urban areas. Although these figures represent a substantial increase since 1948, there is still less than one bed per 10,000 population and less than one mental health professional per 100,000 population.

With regard to the question of who provides counseling and therapy in China, Shi and colleagues (2005) recently conducted the most comprehensive survey of mental health counselors to date. The authors surveyed 258 counselors from a variety of clinical settings. Results indicated that the majority were physicians (e.g., psychiatrists, neurologists, and general practitioners) and individuals with college-level training in psychology or education. In

addition, a significant number were nonspecialists who had received minimal training in counseling to enhance their work in industry, prisons, and schools. Among those reporting their educational credentials, 11.7% had a doctoral degree, 32.6% a master's degree, 42.2% a baccalaureate degree, and 13.5% an associate's degree. (There are two training levels of physicians: higher-level doctors study general medicine at a medical school for 5 or 6 years, while the lower-level doctors complete a 3-year course of education at a health school [Pearson & Phillips, 1994]. Unlike the United States' requirement of a bachelor's degree prior to enrollment in medical school, promising Chinese students enter medical school following high school graduation, and upon receiving a baccalaureate degree in medicine, they enter the ranks of the medical profession.)

Because very few universities in China offer coursework in psychotherapy or counseling, the majority of the sample received their training through continuing education programs such as the Department of Labor's Mental Health Counseling Program, the German-Chinese Psychotherapy Training Program, the International Psychosomatic Medicine Training Program (Wuhan), and the Training Program for Psychoanalysis (Nanjing). However, it is important to note that Shi and colleagues focused primarily on counselors working in clinical settings. Relatively little is known about the training and education of those dispatched to the nation's primary and secondary schools, prisons, and disaster sites.

Despite the limitations of their study, Shi et al.'s (2005) findings suggest some important differences in the training of counselors in China when compared to the United States. First, there is great variability in the quality and amount of training received by practicing counselors. For example, the Mental Health Counseling Program run by the Department of Labor has three levels of certification involving 144 hours, 24 days, or 3 months of training. In order to regulate professional practice, licensing requirements for mental health counselors recently have been drafted and an enforceable ethics code is presently under development.

Second, because many counselors are physicians by training, the practice of counseling in China frequently involves an integration of psychological and medical treatments. Psychiatric medications, medicinal herbs, acupuncture, moxibustion (i.e., the application of heat to areas of the body), and breathing and movement exercises may all be prescribed as adjunctive treatments (Qian et al., 2001). Examples of the latter include *taiji quan*, an internal martial art and Chinese form of exercise consisting of a sequence of postures linked by gentle flowing movements, and *qi gong*, loosely translated as energy cultivation, a self-healing practice that combines movement, controlled breathing, and meditation. The application of a holistic approach to mental health care is consistent with patients' expectations of treatment, as

discussed previously, as well as traditional medical theories of the interconnections between the mind and the body.

### FUTURE DIRECTIONS

As we hope we have demonstrated, exciting developments in counseling and therapy are currently underway in the People's Republic of China. The social and economic transformations of the past 25 years have created a new mental health industry that promotes wellness and prevention in addition to treatment. Although influenced by Western approaches, contemporary Chinese forms of counseling and therapy have evolved into new hybridized forms that take into account Chinese cultural beliefs, philosophical traditions, and help-seeking practices. Indigenous healing approaches, such as *taiji quan* and *qi gong*, continue to be practiced alongside these new therapeutic technologies. This flowering of the profession is a sign of health and will serve to further democratize the counseling field. For example, more traditional Chinese clients may derive more benefit from treatments that are a closer cultural match, while more Westernized Chinese clients may be drawn to those very approaches that represent a departure from traditional value orientations. The geographic, cultural, and economic diversity of the Chinese people attests to the need for flexible counseling models that assess each client's place within a larger social and ecological context.

However, so far there have been few investigations of the effects of sociodemographic and cultural variation on clinical outcomes. In this regard, the multicultural counseling/therapy approaches that have been developed in the United States may be particularly instructive (Sue & Sue, 2003). Given that some Western therapies have been successfully adapted to the Chinese cultural context, we argue that Western counseling approaches also have much to gain from cross-fertilization. American mental health counselors working with Chinese clients may benefit from learning about the strategies Chinese mental health counselors have found effective. In addition, indigenous Chinese therapies may prove increasingly useful to Western clients, particularly as Buddhism, Taoism, and traditional Chinese medicine become more influential in mainstream U.S. society.

We hope that this article helps to encourage American mental health counseling professionals to seek opportunities for dialogue and mutual sharing of knowledge with our Chinese counterparts. Advances in counseling theory and practice within the Chinese context will contribute to the development of more valid models for working with the one-fifth of the world's population that is Chinese, in whatever country they may find themselves.

## REFERENCES

- Blowers, G. H. (1994). Freud in China: The variable reception of psychoanalysis. In G. Davidson (Ed.), *Applying psychology: Lessons from Asia-Oceania* (pp. 35–49). Brisbane, Queensland, Australia: Australian Academic Press.
- Bond, M. H. & Hwang, K. K. (1986). The social psychology of the Chinese people. In M. H. Bond (Ed.), *The psychology of the Chinese people* (pp. 213–266). Hong Kong: Oxford University Press.
- Chang, D. F. (2001). The cultural validity of neurasthenia: Psychiatric diagnosis and illness beliefs in a Chinese primary care sample (Doctoral dissertation, University of California, Los Angeles, 2000). *Dissertation Abstracts International*, 61(7-B), 3835.
- Chen, C. P. (1995). Counseling applications of RET in a Chinese cultural context. *Journal of Rational-Emotive & Cognitive Behavior Therapy*, 13, 117–129.
- deShazer, S., & Berg, I. K. (1986). Brief therapy: Focused solution development. *Family Process*, 25, 207–221.
- Dong, J., Li, X., Tian, Z., & Wen, Q. (1980). Behavior modification treatment of obsessive-compulsive neurosis. *Chinese Journal of Neurology and Psychiatry*, 13(3), 161–163.
- Fang, M., Li, C., & Sun, Y. (1990). The combination of aversion, covert sensitization, and positive stimulation in the treatment of 16 sexual deviants. *Chinese Mental Health Journal*, 4(5), 223–225.
- Freud, S. (1900). The interpretation of dreams. *Standard Edition*, 4-5, 1–625.
- Guo, N. (1987). Social investigation and analysis of mental health problems. *International Journal of Mental Health*, 16(3), 43–50.
- Ji, J. L., & Xu, J. M. (1989). Cognitive-behavioral therapy. *Chinese Journal of Mental Health*, 3, 129–132.
- Jia, R., & Sun, W. (1995). Systematic desensitization treatment for gas-mask phobia. *Chinese Mental Health Journal*, 9, 29–31.
- Kou, Z. (1998, November 30–December 6). Psychiatrist's couch no longer shunned. *Beijing Review*, 41, 16–17.
- Lee, S. (1998). Estranged bodies, simulated harmony, and misplaced cultures: Neurasthenia in contemporary Chinese society. *Culture, Medicine and Psychiatry*, 60, 448–457.
- Li, M.-G., Duan, C., Ding, B.-K., Yue, D.-M., & Beitman, B. D. (1994). Psychotherapy integration in modern China. *Journal of Psychotherapy Practice & Research*, 3, 277–283.
- Min, Z. (2001, May 23). Mental health care widens in China. *China Daily*. Retrieved February 1, 2002, from [http://www.chinadaily.com.cn/en/doc/2001-05/23/content\\_58753.htm](http://www.chinadaily.com.cn/en/doc/2001-05/23/content_58753.htm)
- O'Neill, M. (2004, March 2). Disc drivers. *South China Morning Post*. Retrieved June 13, 2004, from <http://www.scmp.com>
- Pearson, V. (1995). *Mental health care in China: State policies, professional services and family responsibilities*. London: Gaskell.
- Pearson, V. (1999). Words mean what I want them to mean: The analects meet Alice. *Transcultural Psychiatry*, 36, 231–247.
- Pearson, V., & Phillips, M. R. (1994). The social context of psychiatric rehabilitation in China. *British Journal of Psychiatry*, 165(Suppl. 24), 11–18.
- Phillips, M. R., Liu, H., & Zhang, Y. (1999). Suicide and social change in China. *Culture, Medicine & Psychiatry*, 23, 25–50.
- Psychological clinics enter Chinese prisons. (2002, December 29). *People's Daily Online*. Retrieved February 22, 2004, from <http://english.peopledaily.com.cn/>
- Psychological consulting on the increase. (1995, May 8–14). *Beijing Review*, 38, 28–29.

- Qian, M., & Chen, Z. (1998). Behavior therapy in the People's Republic of China. In T. P. S. Oei (Ed.), *Behavior therapy and cognitive behavior therapy in Asia* (pp. 33–46). Glebe, New South Wales: Edumedia.
- Qian, M., Smith, C. W., Chen, Z., & Xia, G. (2001). Psychotherapy in China: A review of its history and contemporary directions. *International Journal of Mental Health, 30*, 49–68.
- Shi, Q. J., Sang, Z. Q., Li, X. Q., Zhou, J., & Wang, H. F. (2005). Current status of counseling and psychotherapy in China. In Q. J. Shi, Q. F. Zeng, X. C. Sheng, & W. Senf (Eds.), *Psychotherapy: Theories and practice* (pp. 21–34). Beijing, China: Chinese Medicine Pharmacy Science Publishing House.
- Sue, D. W., & Sue, D. (2003). *Counseling the cultural diverse: Theory and practice* (4th ed.). New York: John Wiley & Sons.
- Tung, M. (1984). Life values, psychotherapy, and East-West integration. *Psychiatry: Journal for the Study of Interpersonal Processes, 47*, 285–292.
- Tung, M. (1991). Insight-oriented psychotherapy and the Chinese patient. *American Journal of Orthopsychiatry, 61*, 186–194.
- Veith, I. (1997). *Huang Ti nei ching su wen: The yellow emperor's classic of internal medicine*. Selangor Darul Ehsan, Malaysia: Pelanduck Publications.
- Wu, J. (1994). On therapy with Asian patients. *Contemporary Psychoanalysis, 30*, 152–168.
- Xu, J., & Ji, J. (1996). Cognitive therapy in China. In Y. X. Xu (Ed.), *Cognitive psychotherapy* (pp. 9–10). Guizhou, China: Guizhou Educational Press.
- Yi, K. (1995). Psychoanalytic psychotherapy with Asian clients: Transference and therapeutic considerations. *Psychotherapy: Theory, Research, Practice, Training, 32*, 308–316.
- Young, D. (1996). Chinese people's mind and Chinese specific psychotherapy. In W. S. Tseng (Ed.), *Chinese people's mind and therapy* (pp. 417–435). Taiwan: Guiguan.
- Zhang, Y., & Yang, D. (1986). A comparative study of systematic desensitization and suggestion in the treatment of hysteric patients. *Chinese Journal of Neurology and Psychiatry, 19*(5), 297–298.
- Zhang, Y., Young, D., Lee, S., Li, L., Zhang, H., Xiao, Z., et al. (2002). Chinese Taoist cognitive psychotherapy in the treatment of generalized anxiety disorder in contemporary China. *Transcultural Psychiatry, 39*, 115–129.
- Zhong, Y. (1988). *Chinese psychoanalysis*. China: People's Publications of Lian Nin.
- Zhong, Y. (1992). Psychology and psychotherapy in China. *Journal of Chinese Psychological Hygiene, 5*, 38–40.

Copyright of Journal of Mental Health Counseling is the property of American Mental Health Counselors Association and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.