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How do Chinese Cognitive-Behavioural Therapy Trainees View Their Own Therapy Competence and the Cultural Compatibility of this Therapy for Chinese Clients with Depression in Hong Kong?

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Abstract

Background: There is growing need and demand for the application of and training for cognitive-behavioural therapy (CBT) in different cultures. While there are increasing evidences to suggest that CBT is applicable to people of different culture backgrounds, such as the Chinese in Hong Kong, there is a lack of a documentation concerning the training of CBT practitioners of different cultural backgrounds. Aim: This article aimed to document the subjective experience of 20 trainees who undertook our one-and-a-half-year cognitive-behavioural therapy (CBT) training programme. Method: In-depth interviews were carried out with all of the trainees, and these interviews were transcribed and coded. Results: Content analysis of the transcripts suggests that the trainees had gained an understanding of the CBT framework and felt competent in facilitating clients' acquisition of adaptive cognitive and behavioural responses. They were less confident in facilitating the modification of rigid dysfunctional rules and values. Many of the trainees mentioned the culturally attuned CBT exercises and worksheets as being useful in helping clients to acquire cognitive and behavioural strategies to handle their distress and depressive moods. With regard to the modes of training, the trainees were particularly appreciative of the live demonstration and coaching. Lastly, these trainees considered CBT to be culturally compatible with Chinese values and with Chinese people's preference for certain styles of therapy practice. Conclusions: The findings are useful as a reference for developing CBT training for practitioners of Chinese-speaking backgrounds.

Keywords: Cognitive-Behavioual Therapy, professional trading, Chinese

Introduction

There is a growing need for and interest in the application of and training for cognitive-behavioural therapy (CBT) in different cultures. In many places, such as Hong Kong, people who suffer from depression primarily receive medication, and few alternative treatments are available (Yip, 1998). Moreover, the waiting list for psychotherapy and counselling services is very long. In the past few years, various psychotherapeutic approaches, including CBT, have been used in Hong Kong to treat people who suffer from depression. The results of these approaches echo overseas findings and suggest that they are applicable to and effective for people with mild and moderate major depression in Hong Kong

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(Beck, 2005; Bulter, Chapman, Forman & Beck, 2006; Wong, 2007, 2008).

A number of researchers have suggested that therapist competence in CBT is related to client outcome (Shaw et al., 1999; Trepka et al., 2004), and CBT training has led to improvements in trainee competence (James, Blackburn, Milne & Reichfelt, 2001). Studies have also found that CBT training in the 'workshop' format alone is of limited value (Walters, Matson, Baer & Ziedonis, 2005). Although CBT training courses have been associated with improvements in clinical competence (Sholomskas et al., 2005) and therapist confidence (Benett-Levy & Beedie, 2007), very few studies have attempted to explore the subjective experience of trainees who have undergone this training (e.g., Bennett-Levy & Beedie, 2007). In addition, there is a lack of documentation on the experience of trainees of a certain cultural background in learning and then applying CBT in specific cultural groups. The study reported herein aimed to fill this gap in the literature by documenting the experience of Hong Kong Chinese CBT trainees in learning and applying CBT at six-months post-training.

The SET model of CBT training for Chinese professionals in Hong Kong

Our CBT project, which was funded by the Mrs Li Ka Shing Fund, followed a self-developed model, which we conveniently called SET, as it comprised three components: Service, Evaluation and Training. All three of these components were simultaneously enacted as the project unfolded.

Training

Twenty trainees with a social work background underwent the CBT training programme, which lasted for one and a half years. All of the trainees were required to have at least a Bachelor's degree in social work and two years of social work experience. During the training period, they were coached to run three CBT groups and three CBT workshops for people with depression in Hong Kong, and they were regularly provided with individual and group supervision. Different training modes were adopted, including the following. (a) Three-day training workshop – during this workshop, the trainees were introduced to Beck's models of depression and anxiety, case conceptualisation, and the uses of cognitive and behavioural strategies and group-work skills. (b) Demonstration – the trainees were given the opportunity to observe how the trainers run a 10-session CBT group and a three-session workshop. Debriefing took place immediately after each session of the workshop and group. (c) Coaching and supervision – two trainees from the same agency co-ran three CBT workshops and groups with one of the three experienced CBT therapists and trainers. Debriefing was conducted at the end of each session to help the trainees to capitalise on what they had learnt. In the first sets of workshops and groups, the trainers took on the major responsibility in running the groups and the workshops and the two trainees were asked to observe the trainers in running the activities, with gradual increase in involvement at the later stage of the groups and the workshops. In the second and third groups and workshops, the trainees ran the activities on their own with the assistance of the trainers. Debriefing took place at the end of the sessions to review the learning experiences. Two of the trainers had received their CBT training from the Beck Institute, and the other had received it through a Master degree in mental health. All three of the trainers were experienced CBT practitioners who had co-run many CBT groups in Hong Kong. (d) Consultation – three monthly group consultations that allowed all of the trainees and trainers to meet and discuss the application of and difficulties in running CBT groups and workshops were arranged.

Service

The service component included the development of a three-session workshop with manuals for the general public and a 10-session CBT group for people with depression in Hong Kong. The manuals followed the cognitive model of depression proposed by Beck, Rush, Shaw and Emery (1979). Each workshop session lasted for three hours. In the first session, the objective was to arouse people's interest in and understanding of depression and how cognitive therapy may be used to help treat it. The second and third sessions provided a number of cognitive and behavioural techniques for handling stress and depressed moods. The CBT group, in contrast, was intended to teach cognitive and behavioural strategies to people with mild to severe depressive symptoms to help them to handle their depressive moods. During the first five sessions, attempts were made to help the participants to understand their maladaptive patterns of physiological, cognitive, behavioural and emotional responses to stressful external life events. They were also taught five cognitive and behavioural strategies for managing depressed emotions. We collectively termed these the 'Five Strategies': (1) recognising one's specific physiological responses (i.e., the alarm signals), (2) thought stopping, (3) disputing questions, (4) distraction and (5) a positive self-statement and cue cards. During the fourth to ninth sessions, the participants were also encouraged to come up with a pleasurable activity that they would try to accomplish during the week. The sixth to eighth sessions focused on helping them to identify their dysfunctional rules and values and to examine how they might be putting too many expectations on themselves and others through rigid such rules and values. They were also introduced to different strategies for challenging and modifying these dysfunctional rules and values, including the cognitive continuum, the advantages and disadvantages of holding onto rules, and behavioural experimentation. In the ninth session, the participants had the opportunity to examine their priorities in life through an activity called 'the auction game – the game of life'. They were encouraged to set short- and long-term goals for working towards these new priorities. In the final session, the participants were asked to recount and capitalise on their group experiences.

To adjust the sessions to the cultural characteristics of Chinese people, all of the technical terms were translated into colloquial expressions. First, for example, 'automatic thoughts' was renamed 'thought traps', and the cognitive distortion of 'personalisation' was rephrased as 'putting all blame and responsibilities onto oneself'. Second, we designed a number of worksheets and exercises in Chinese to facilitate the understanding of cognitive and behavioural processes and the learning of cognitive and behavioural skills. Third, we emphasised the exploration and modification of dysfunctional rules related to family and interpersonal relationships. Clinical experience and a review of the literature both lead to the conclusion that Chinese people have many family and interpersonal relationship rules that can become a potential source of stress for them (Tam & Wong, 2006). Fourth, given our understanding that Chinese people prefer a structured therapeutic process with the active involvement of the group leader (Sue and Sue, 1990), our group leaders were actively involved in structuring and facilitating the group processes, particularly in the initial stages. Lastly, the group leaders delivered mini-lectures and provided the participants with a detailed explanation of the exercises and worksheets.

Evaluation

Our project adopted a randomised waitlist control design to evaluate the participants' outcomes following the CBT group sessions. Details of this research design have been

presented elsewhere and thus are not repeated here (Wong, 2007, 2008).

This article reports the CBT training received by the 20 professional social work trainees and, in particular, documents their subjective experience of this training. The following questions were put to the trainees, and these formed the study's research questions.

1. After having completed this training, how confident are you in applying the CBT strategies to work with depressed clients in a group setting?

2. What did you like or dislike about the different training modes used in the programme?

3. How useful were the exercises and worksheets in facilitating changes in clients' moods?

4. How culturally appropriate do you think CBT is for Chinese people with depression in Hong Kong?

Method

Study design

As we wished to gather the personal experiences of the trainees who had gone through our CBT training programme, we decided to adopt a qualitative in-depth interview approach to explore how they felt about these experiences. All 20 of the trainees, who came from 10 social service organisations in Hong Kong, were interviewed.

Procedure

A number of questions were developed to guide the semi-structured, open-ended, face-to-face interviews. The interview schedule was developed by the principal researcher. The questions included the following. 'After having gone through this training, how confident are you about applying the CBT strategies when working with depressed clients in a group setting?' 'How culturally appropriate do you think CBT is for Chinese people with depression in Hong Kong?' As all of the trainees were to be interviewed, no pilot test was carried out. Each interview, which lasted for about an hour and a half, was audio-taped and transcribed for analysis.

Data collection, reduction and analysis

A coding system was developed through a review of all of the transcripts, with each additional transcript adding new codes or modifying existing ones. The transcripts were coded by the interviewer, who was a social work graduate with four years of experience as a research assistant. The coding was then cross-checked by the principal researcher. Since the principal researcher worked very closely with the research assistant in developing the coding system, no disagreement was found between them. Content analyses were carried out to identify the major themes in the trainees' experience of CBT training.

Trustworthiness of the data

All of the interviews and coding were conducted by the same research assistant. The principal researcher carried out the first interview with this assistant and guided her in asking questions that were consistent with the interview guide. Two independent judges with at least a Master degree in social sciences were asked to review two randomly selected transcripts to judge the accuracy of the coding. The level of agreement between these two judges was about 95%.

The informants

In-depth interviews were carried out with all of the trainees, 80% of whom were female (n = 16); 60% had a Bachelor's degree in social work, with the remainder holding a Master degree in the same field. The majority had more than five years of post-qualification experience. One (5%) had just two years of experience, seven (35%) had between five and 10 years of experience, and the rest (60%) had 10 or more years of experience. The trainees worked in family social service centres (65%, n = 13), mental health services (20%, n = 4), counselling services (10%, n = 2) and youth services (5%, n = 1). Over 90% of them described their work as involving individual and group counselling, and 25% said they also engaged in administrative duties (n = 5). Although 14 of the trainees had no exposure to any extended or systematic form of therapy training prior to receiving training from us (70%), three of them had undergone Satir family therapy training and two had training in systemic and structural family therapies. Lastly, one had undergone narrative therapy training.

Results

The majority of the trainees admitted that they had not had systematic training in CBT before undergoing our training programme (n = 14). They had instead learned about CBT through their university studies, a single workshop or by reading relevant books. The majority of them also reported that, during the training programme, they had learned to systematically apply CBT in running groups and workshops for people with depressive symptoms (n = 13).

Level of self-perceived therapist competence in applying CBT

Generally speaking, the trainees were more confident about applying the skills they had learnt to help clients to become aware of and manage their thought traps (i.e., negative automatic thoughts) (n=14) and less confidentabout using those skills to help clients to understand and deal with their dysfunctional rules (i.e., intermediate beliefs) (n=8), as can be seen in the following transcript excerpts.

Table 1
How confident are you in applying CBT strategies?

1. Before the training - Very little knowledge of CBT	14
2. After the training, - Learned to apply CBT in a systematic way	13
3. Feel confident that he/she is able to facilitate clients to understand ATs and dysfunctional rules and values	14
4. Feel confident that he/she is able to facilitate clients to use different cognitive and behavioural strategies to deal with emotions	14
5. Feel confident that he/she is able to facilitate clients to modify dysfunctional rules and values	8

Before training, I did not know about cognitive therapy (CT). I learnt a little bit about CBT when I studied at university. I tried to use some of the concepts when running groups, but never used the therapy systematically. After the training, I feel I have more understanding of the concepts and how to apply them in running workshops and groups (C3). **(Greater understanding of CT concepts)**

I feel I have more knowledge and skills in using CT concepts to assess my clients, helping them examine their thought traps (i.e., negative automatic thoughts) and dysfunctional rules (i.e., intermediate beliefs). The more I understand these, the more I see how entrenched dysfunctional rules and core beliefs are, through repeated life experiences. I must say, I am still not fully confident in helping clients to modify their rules and core beliefs as these are rather deep-rooted (C5). **(More able to use CT concepts to assess and work with clients)**

It is apparent from the following transcript excerpts that the trainees had also acquired greater confidence in using certain cognitive-behavioural techniques to help clients to handle their negative automatic thoughts. Many of them mentioned, in particular, that they were now able to help clients to recognize their own negative automatic thought patterns; understand how these patterns affected their emotions and behaviour (n=14); and use the Five Strategies to handle their emotions: recognising one's physiological responses (i.e., the alarm signals), thought stopping, self-disputing questions, distraction, and a positive self-statement and cue cards (14).

I find the exercises and worksheets useful for helping clients understand and handle their negative automatic thought patterns. They are user-friendly, and I know how to use them. I must say clients picked up on their thought patterns fairly quickly. For example, one woman in the group used to engage in 'catastrophising thoughts', believing that if she allowed the air from the exhaust fan next door to enter her apartment, the whole family would get cancer, and they would all die from it. She would then shut the windows. After she had gone through the exercises, she realised she might be engaging in catastrophising thoughts. Then she instructed herself to 'stop', distracted herself by drinking a cup of tea and told herself not to over-dramatise the situation. I felt happy that I was able to facilitate her in developing these strategies (C3). **(Feeling confident in facilitating the awareness of thought traps and the use of thought stopping, distraction and self-disputing questions)**

The most valuable advice I got in the training was to 'practice and learn'. However much the trainers gave us, we still need to practice. I feel that I have now gained a sense of direction when counselling a client and know what questions to ask them. . . . It is now easier for both myself and the group participants to understand and identify their thought traps and for them to use the Five Steps to handle their negative automatic response patterns (C17). **(Had gained more confidence in facilitating the awareness of thought traps and the use of the Five Strategies)**

However, from the following excerpts, it can also be seen that the trainees expressed doubts about their ability to facilitate clients in relaxing their dysfunctional rules (n=6).

If we could facilitate the members in relaxing their dysfunctional rules, it would be great. Many depressed people are so rigid with their rules, which suffocate them. That's why they are so unhappy. It is difficult to help them identify which specific dysfunctional rules are affecting them. I must say we as social workers had difficulties identifying ours. Some felt that their rules were legitimate and that there was nothing wrong with them (C9). **(Difficulty helping clients to identify and understand the dysfunctional nature of certain rules)**

Rules are hard to relax. It is not that they did not realise that they had certain dysfunctional rules. Some did. However, many group participants did not know how to relax these dysfunctional rules. When we as social workers cannot fully grasp the skills to do so, it becomes much more difficult for us to teach group participants to do so (C14). **(Difficulty helping clients to relax their rules due to inadequate skills)**

Evaluating the usefulness of CBT exercises and workshops

The trainees acknowledged that the following exercises were useful in facilitating changes among group participants. Some are behavioural strategies, and others such as mood checks are a form of scaling. The activity ruler is an exercise intended to increase the motivation and energy levels of participants (n=13). Essentially, the group participants were asked to make a list of pleasurable activities that they could engage in between group sessions. Every week, the group leaders would help them to develop a concrete plan for carrying out these activities and also rewarding themselves should they complete them. The following transcript excerpts show that the trainees found these exercises to be beneficial to the group members.

Table 2

Which training modes do you find helpful to your learning?

1. Coaching and supervision	13
2. Demonstration	12
3. Three-day training	9
4. Three-monthly consultation	6

Our clients were quite depressed and felt that they could not achieve anything. When they started to do the activities, just small things, they felt they had achieved something. The exercise was important to help them realise that it was them who made the changes happen. We needed to hammer that into their minds (C3). *(Appreciating the usefulness of the activity ruler)*

The activity ruler was not hard to understand, and group participants could easily grasp it. One mother had a hyperactive child and felt she could not manage the child outside the home. She decided to try, and the child had a great time. So did she. She realised she could do it (C15). **(Appreciating the usefulness of the activity ruler)**

An emotion thermometer was used at the beginning of each group session to help the group participants (1) to express and release their emotions, (2) to become aware of the maladaptive physiological, behavioural and emotional response patterns they each presented, and (3) to develop new and adaptive physiological, behavioural and emotional responses (n=11). However, some of the trainees expressed concern that this exercise consumed too much time and made it difficult

to complete the stated session goals, as can be seen in the following transcript excerpts (n=7).

The emotion thermometer (i.e., a mood check) helped the members to be aware of their emotions. Generally speaking, people with depression will describe themselves as unhappy, but cannot concretely say how depressed they are. The emotion thermometer helped them concretize their feelings. Moreover, we could make use of the change in 'temperature' and help them to see the subtle change and what might have happened that could have contributed to the difference (C4). **(The emotion thermometer was useful in helping clients to concretize their feelings and to see subtle changes)**

The emotion thermometer was able to increase members' awareness of their emotions. When members started to talk about their emotions, they talked and talked and talked, and exceeded the time limit. We did not want to stop them because they needed to air their emotions. We had great difficulty trying to catch up with the rest of the activities prescribed in the session goals (C1). **(The emotion thermometer delayed the group process)**

Evaluating the usefulness of various training modes

Different training modes were adopted in this project to maximise the learning opportunities for the trainees. These included three days of training on CBT concepts and skills, as well as on the skills for and logistics of running CBT groups and workshops with clients; a live demonstration; small group coaching provided by the trainers; debriefing after each workshop and group session; and tri-monthly consultations. Many of the trainees commented that coaching was the best method of learning (n = 13); others found the live demonstration on groups and workshops (n=12) and the three-day training session to be quite effective in facilitating learning (n=9). The following excerpts reveal these points.

Table 3

How useful were the exercises and worksheets in facilitating changes in clients' moods?

1. Emotional thermometer	11
2. Activity ruler	13
3. Dysfunctional thought record worksheet	12
4. The Five strategies (e.g. Thought stopping and cue card, etc)	10
5. Self-reward exercise	5
6. Auction game (i.e. priority in life)	7

The three-day training workshop was necessary to give us some idea of what CBT is. I did not expect to learn everything and to be able to use the CBT skills. It was more a way of giving us foundation knowledge of CBT (C12). **(3-day training workshop)**

The trainer ran the workshops and groups (for the clients) with us. When we got stuck, they intervened, and we learned by observing how they used the CBT skills (C16). **(Coaching and live demonstration)**

I really liked the format of coaching because the trainer showed me every step as to how to run the workshop or group. Although I still had to try and develop my own style of practice, I felt I had someone to rely on, and did not have to make too many mistakes (C12). **(Coaching and live demonstration)**

After every session, we were debriefed. The trainer asked what we had observed in the process; why certain skills were used; and helped us reflect on what we had done and suggested how we could improve our CBT skills. I found the debriefing very helpful to my learning (C13). **(Debriefing)**

Compatibility of CBT with Chinese culture

The interview transcripts reveal that the trainees found no major difficulties with regard to the cultural appropriateness of CBT for Chinese people with depression. Indeed, they commented that the CBT framework is compatible with Chinese culture (n=12). Three of the trainees put it as follows.

A theory provides a framework, and when put into a context, be it in Western or Chinese societies, it has to be adjusted. I do feel that Chinese people in Hong Kong engage in a lot of 'assumption of responsibility', and I think this is influenced by the culture. Chinese culture emphasises hierarchies and responsibilities and everyone is more or less asked to behave according to the prescribed roles. Chinese have many rigid dysfunctional rules. The CBT framework fits well with this (C17). **(Chinese have many rules that may be dysfunctional and fit the CBT framework)**

Table 4

How culturally appropriate do you think CBT is for Chinese people with depression in Hong Kong?

1. Overall, CBT is compatible to Chinese	12
2. Chinese culture is rich in having many rules	9
3. Chinese people like structure	8
4. Chinese people are not used to 'think about thinking'	3
5. Chinese people respect authorities and expect the leaders to be directive	5

I do not see any incompatibility. However, I must say that it may be more difficult to relax culture-bound rules. The Chinese have so many of these rules, which put a great deal of pressure on individuals and their families and friends. I don't know enough about Western cultures to make a direct comparison. In Chinese culture, if you do not live with your parents, you are considered as lacking in filial piety. However, living together can be rather stressful for both parties. There are just too many expectations on the individuals involved. Because these rules are so entrenched in the culture, it is difficult to help clients to relax them. After all, you are challenging their fundamental beliefs, which have a thousand years of history to back them up. Having said this, the CBT framework with its emphasis on beliefs fits very well with the culture. When we introduced the CBT framework to our group participants, some could immediately understand how their dysfunctional rules might be affecting their emotions. Of course, understanding does not necessarily make it easier for them to relax the rules (C9). **(Chinese clients can understand the CBT framework, particularly in relation to dysfunctional rules)**

I do not see any problem in adapting CBT to Chinese people. In fact, CBT is rather suitable to the Chinese because it is directive and structured. The concepts are not abstract, and the skills are practical. The Chinese like to learn practical skills that they can apply to themselves (C2). **(Chinese clients prefer therapies to be direct and to teach them practical skills)**

However, a few of the trainees mentioned that some of the group members had had difficulty in 'thinking about their thinking' (n=3) and therefore required a lot of prompting before they became used to reflecting on their thinking process.

I have worked with Westerners before, and my husband is Caucasian. My impression of Chinese people is that we are normally not aware of what we are thinking. We can express our unhappiness and see who is making us unhappy. However, we are not used to examining how our thinking is involved in making us unhappy. My contact with Caucasians indicates that they have a better concept of self and are more aware of what they are thinking when they are unhappy (C5). **(Chinese have difficulty in 'thinking about their thinking')**

Discussion

However careful and sophisticated a study's research design is, there are bound to be limitations, and this study is no exception. First, the study had a small number of cases, because its findings were intended to illuminate how the trainees viewed their CBT training. Thus, these finding cannot be generalised to other CBT trainees elsewhere in Hong Kong or overseas. Indeed, the trainee comments were gathered specifically to improve the organisation and implementation of our own CBT training programme. Second, although the use of in-depth individual interviews was appropriate for this study, and yielded detailed information about the trainees' experience of CBT training, such interviews are nevertheless retrospective in nature. Therefore, some information may have been lost due to the process of recall.

One of the major objectives of this qualitative study was to explore the trainees' subjective feelings about their level of confidence in practising CBT after the training programme had concluded. From analysing the interview transcripts, it is clear that through the systematic training they received, the trainees, in general, had gained more understanding of the efficacy and application of CBT for people with mild to moderate symptoms of depression in Hong Kong. They felt in particular that they now had greater confidence in facilitating group participants' understanding and acquisition of cognitive and behavioural skills in handling negative automatic response patterns. However, they were less confident about helping group participants to learn to relax their dysfunctional rules and core beliefs. Several reasons may be given to explain these findings. Our attempts to translate CT concepts into colloquial terms not only benefitted the clients, but also provided a vocabulary set that the social workers could share with them. For example, 'automatic thoughts' was renamed 'thought traps', and the cognitive distortion of 'personalisation' was rephrased as 'putting all blame and responsibilities onto oneself'. With these colloquial terminologies in place, the social workers were more easily able to educate their clients in understanding Beck's model of depression. In addition, the development of the Five Strategies greatly enhanced the ability of these social workers to help their clients to develop adaptive cognitive and behavioural responses to deal with their stressful life events and depressive moods. Indeed, the Five Strategies comprise practical cognitive and behavioural strategies that can easily be understood by social work practitioners and clients.

Although 'dysfunctional rules' as a concept may not be difficult for either social workers or their clients to understand, it is much more difficult for the former to help the latter to identify the more covert dysfunctional rules and values that drive their overt automatic cognitive and behavioural responses. Although several questioning techniques and worksheets were developed to help the clients (as well as the trainees) to identify specific rules and values, such identification is not a straightforward process, but requires social workers to draw on additional relevant childhood and contextual issues. Intuition and experience are both essential in this identification process. It is also a difficult task for clients to identify their own dysfunctional rules, as doing so requires 'thinking about one's thinking' – a process of reflection that some clients are not culturally accustomed to. To further complicate matters, some dysfunctional rules are culturally espoused, and thus not considered by clients in Hong Kong to be dysfunctional. Thus, it is not difficult to understand why our trainees experienced difficulties in facilitating clients' understanding and relaxation of these rules.

Another objective of the study was to find out how the trainees felt about the exercises and worksheets. At the beginning of the project, we developed a number of exercises and worksheets in Chinese, which we collected into a workbook to be used to help clients to understand and identify their negative automatic thoughts, behavioural patterns and dysfunctional rules, to develop adaptive cognitive and behavioural responses to deal with stressful life events and depressive moods, and to relax their rules. An important part of CBT training in Hong Kong is to help trainees to develop the competence to use these exercises and worksheets skilfully. It appears from the transcripts that the trainees were appreciative of these materials and found them to be useful in facilitating clients' understanding of their thoughts, behaviour and emotions and their development of adaptive methods of responding to stressful events and depressed moods. There is a lack of such Chinese-language materials in Hong Kong. Professionals in social work and other disciplines have had to rely on foreign-language materials that may not be culturally familiar to their clients. Our development of culturally attuned exercises and worksheets has greatly, and in a step-by-step manner, facilitated such professionals in their ability to systematically guide their clients in using CBT to work through their issues.

Of the different modes of training adopted,

it was found that the trainees were particularly appreciative of the live demonstration and debriefing and coaching. Through these modes, the trainees were not only able to observe and model the trainers in translating the concepts into practice, but they were also coached to practise their micro-skills in applying CBT techniques during therapy sessions. James, Milne, Marie-Blackburn and Armstrong (2006) and Ronen and Rosenbaum (1998) have suggested that experiential learning is an important supervisory activity that enhances trainees' acquisition of clinical skills. Remmen et al. (2000) and Bursari et al. (2005) have also maintained that coaching in clinical skills and providing feedback are perceived by medical residents and students as highly useful. During our training programme ,the trainees were given the opportunity to observe a live demonstration of the trainers running a CBT workshop and group session. They were then coached and supervised to practise CBT skills by co-running CBT groups and workshops. On reflection, we can see that the trainees went through a training process that involved Demonstration (live) → Debriefing → Coaching → Supervised Practice. However, our project was not concerned with an examination of this training process and the different training modes used. Future research should explore the effectiveness of this process and the relative effectiveness of the different training modes in facilitating trainee learning of CBT.

Live demonstration and coaching may be perceived as both professionally appropriate and culturally more suited to the learning style of Chinese people, including our professional trainees. From the training point of view, professional trainees in clinical practice, especially inexperienced ones, normally appreciate the demonstration of clinical skills by experienced practitioners. This allows rainees to see clearly how various clinical skills may be delivered in practice. From the point of tview of a Chinese professional who is learning CBT, live demonstration and coaching may be seen as culturally suitable. It is said that Chinese people have the tendency to respect and follow authoritative teachers and expect them to play an active role in giving instructions and offering advice during the learning process (Gow, Balla, Kember & Hau, 1996). Thus, it is not difficult to understand why our trainees were particularly appreciative of such training modes as live demonstration and coaching, which match Chinese learning styles.

Another important objective of this qualitative study was to find out whether the trainees saw CBT as culturally appropriate for Chinese people. It is not difficult to see from the transcripts that the trainees found the theoretical underpinnings of CBT to be applicable to Chinese people, particularly in relation to dysfunctional rules and values. Indeed, when they presented the framework to their clients, they found that they were able to understand it and use it to examine why and how they become upset or depressed. As Lin (2001) and Hodges and Oei (2007) have suggested, CBT is compatible with Chinese culture in a number of ways: (1) the active involvement of the therapist is highly appreciated, as is the (2) teaching of practical and solution-focused skills, (3) the emphasis on homework, and (4) the strong adherence to rules, norms and imposed structures without scrutiny. Thus, the theoretical foundation and practice of CBT appear to suit the cultural characteristics of Chinese people, and it is no surprise that the majority of the trainees agreed.

However, a few of them also mentioned that Chinese people are not used to 'thinking about their thinking', and that they also have difficulty in challenging their dysfunctional rules because of their unquestioning acceptance of certain traditional rules and values. These two observations may be related to the fact that Chinese people have the tendency to engage in rote memorisation and to accept what are taught by teachers as authoritative and not to be questioned (Gow, Balla, Kember & Hau, 1996; Hodges & Oei, 2008). Thus, Chinese clients may not be used to examining their own thought patterns and discovering the covert dysfunctional beliefs that are hidden behind their overt automatic cognitive and behavioural responses. It is important for practitioners who work with this population to be aware of this trait and ready to provide more help to these individuals. Two strategies are often used in our practice. First, during the workshop or group session, the group leader reframes illogical or irrational thoughts as rigid and unhelpful, thus minimising possible misperceptions among clients that he or she is challenging long-held Chinese core values. Moreover, the leader also emphasises the importance of relaxing, rather than discarding, one's rules and values. The second strategy that the leader uses is to prompt clients more often so that they become more familiar with the process of examining their own thinking patterns and identifying their thought traps and dysfunctional rules.

Implications

Although individual trainees in this study might have acquired different levels of confidence in applying CBT techniques to work with Chinese clients with depression, they nevertheless seemed to agree that a structured and manualized CBT group is suitable for Chinese depressed clients in Hong Kong, and is compatible to Chinese culture. In view of the large number of Chinese people in Hong Kong and overseas who may be suffering from depression or depressive symptoms, it is therefore recommended to further develop a Chinese CBT depression manual so that mental health professionals can follow the step-by-step procedures to conduct CBT groups for Chinese clients with depression or depressive symptoms. The manual to be further developed should be culturally attuned, with wordings that are colloquial and exercises and worksheets that can be easily understood and used by the participants and the workers. Indeed, it would be useful to develop a worker's manual alongside the development of the participant's manual so that professionals can follow the procedures to run the CBT depression group.

Like other therapies, the success of CBT relies on highly skilled practitioners who are well-versed with the theories and techniques in CBT. It is therefore essential to provide systematic training in CBT in the undergraduate and postgraduate counselling and mental health curriculums in the Hong Kong's and overseas' universities. Alternatively, further professional training for graduates in counselling and mental health fields can be organized to systematically train these professionals to use CBT in working with Chinese clients with depression. The training contents should cover: (1) theoretical understanding of CBT for people with depression, (2) the use of group dynamics, (3) skills learning (i.e. with demonstrations), and (4) supervision and coaching on the application of CBT for depressed clients. In this study, we have highlighted a CBT training model we developed for professionals who were working with Chinese depressed clients. More initiatives in developing CBT training models for professionals of Chinese or other ethnic backgrounds are highly essential.

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摘要

認知行為療法的華人受訓者如何看待自身的治療能力感和使用該療法治療香港抑鬱症患者時的文化兼容性

Daniel F K Wong

研究背景：認知行為治療（CBT）發展至今，眾多的證據顯示認知行為治療適用於不同文化背景的群體，例如將治療方法應用於香港華人。與此相關的認知為治療培訓的需要亦與日俱增。然而，目前缺乏一些有關此類訓練的相關資料。

研究目的：分析20名接受為期一年半的認知行為治療（CBT）課程訓練的學員(專業人仕)的主觀經驗。

研究方法：所有學員皆接受深入訪談，並將訪談內容轉錄和編碼。

研究結果：訪談內容的分析顯示，學員掌握到認知行為治療的理論架構，並有信心協助個案掌握正面的認知及行為適應策略；但部份學員卻希望有更多的時間用於演練一些重塑不良思想規條及價值觀的技巧。另外，許多學員均表示認知行為治療練習和工作紙能有效地讓個案掌握一些認知及行為的策略，舒緩個案內心的苦惱及抑鬱情緒。就訓練模式而論，學員十分欣賞現場示範和指導的部份。最後，學員們認同認知行為治療能融合於中國文化價值觀，且是華人合宜的一種治療模式。

總結：研究結果為培訓華語背景的認知行為治療工作員提供一份重要的參考文件。

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