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Effectiveness of Cognitive Behaviour Therapy (CBT) for People with Depression in Hong Kong: Reflections on Recent Research Findings

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Introduction

Thank you very much for inviting me to come and talk about an area that I am very passionate about - which is about Cognitive Behaviour Therapy (CBT). But let me start off by saying that I really appreciate the previous two speakers who have been talking about the importance of a multidisciplinary integrated approach to helping people with depression and anxiety disorders.

One of the questions that came to my mind in the past hour or so is - what is the meaning behind performing expressive arts and physical exercises, as spoken by the previous two speakers? How do these relate to CBT? CBT has traditionally been seen as a "rational" therapy - you help your client rationally understand his/her situation and engage in self-disputing of his/her 'irrational beliefs'. Through this process, the client's emotions improve. I must say this is a very dated view of CBT, and I am going to suggest that changes in cognitions must be accompanied by changes in one's new experience of the situation. Without new experiences the person will not be able to make substantial changes cognitively and emotionally. In our line of work, our team has adopted the Beckian CBT model in facilitating changes in people's lives.

There are many studies that have demonstrated the positive effects of CBT for depressive and anxiety disorders. I don't think I need to give you details of these studies as you can find them in different journals easily. Underlying this effectiveness is the process whereby CBT helps an individual change his/her internal cognitions from negative views of oneself, others and the future and modify one's dysfunctional response patterns into more balanced views of oneself and others and the future. The process also involves helping the person see how his/her dysfunctional attitudes, values and rules in life are affecting his/her negative moods. Indeed, in the treatment of depression, helping people change their dysfunctional attitudes, values and rules have been an important focus of our CBT intervention.

One important therapeutic principle behind CBT is guided discovery. The whole process of our work is to guide the individual to 'self-discover' his/her own patterns of cognitive, emotional and behavioural responses and to develop new adaptive patterns of responses. The whole idea behind is to enable the person to acquire life-long strategies to deal with his/her negative response patterns that have led and may lead to recurrent depressive and anxious moods in the future.

Concerning group CBT we do know there are many studies that support the effectiveness of group CBT for depression and anxieties. How does that work? In addition to the components pertaining to cognitive, emotional

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and behavioural interventions and changes, changes can also be enhanced through group dynamics - the process of social connectedness, mutual support and edification from the group members. Moreover, the group also helps individuals develop behavioural plans and encourages members to implement the activities which invariably lead to acquisition of new experiences in life. Let me emphasize this again - by engaging in new activities individuals acquire new experiences in life and this is very important for cognitive transformation.

Some studies suggest that psychopharmacology and CBT have similar short-term effects with results that are very comparable. However, there are some studies that mention that the relapse rate for psychopharmacology is higher than that of CBT after the termination of medication and CBT treatments. Of course there are other studies which do not support this idea. All one can say at this moment is that, the issue is inconclusive.

CBT for depression and anxieties among Chinese

Having given you a brief overview of the current state of CBT, let's talk about the issues surrounding the effectiveness of CBT treatments for Chinese people with depression and anxieties. You have heard so much about its effectiveness with other cultural groups. But how effective is it in the Chinese populations? I shall use my own studies to give you an idea about what has been the treatment outcomes as there are not many other outcomes studies among Chinese populations in the major academic journals.

Before I launch into this, let me introduce very briefly one important centre that is involved in CBT work in Hong Kong. The centre is called The Institute of Cognitive Therapy. This is a training and research institute independently established by a group of enthusiasts in CBT, and all board members have university affiliations. The

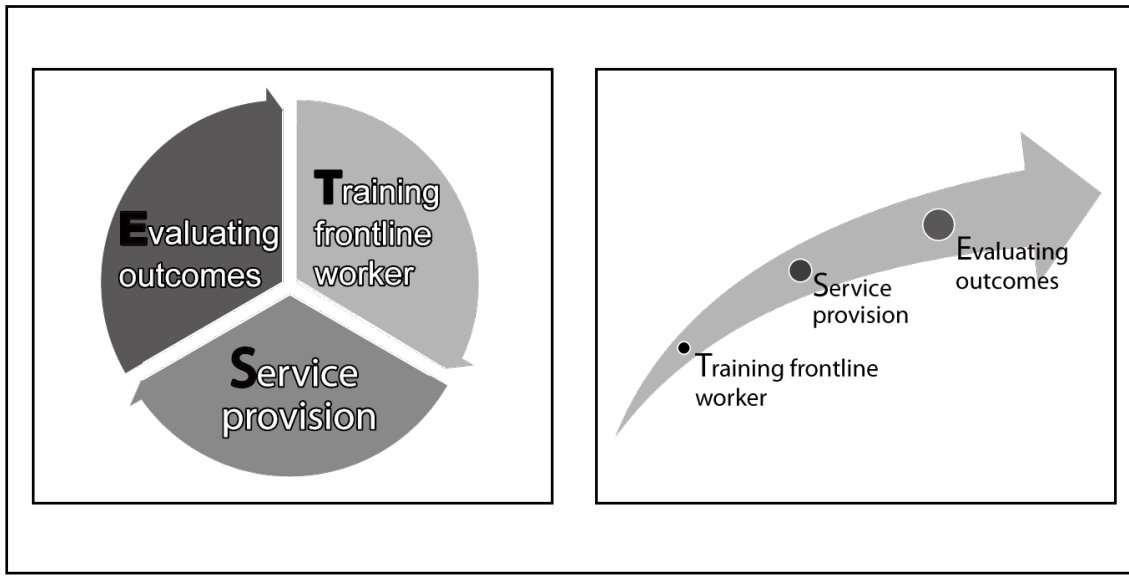

Figure 1: Project structure (SET)

ultimate objectives of this unit are (1) develop culturally relevant CBT models for Chinese people with mental health concerns, (2) conduct evidence-based process and outcome studies relating to CBT, and (3) to train up professionals who can competently use CBT to facilitate changes in their clients. Indeed, we have developed a working model called "SET" - **S** for services, **E** for evaluation and **T** for training (Figure 1). In the past few years we have been very fortunate to have received more than eleven CBT project funding from both government and NGOs such as the Social Welfare Development Fund. Besides, the institute also conducts two-year CBT certificate training and day-long workshops in CBT for professionals who are going for certification as a CBT therapist. In addition, we help NGOs develop new and innovative CBT projects. Lastly, we produce CBT Chinese materials in the forms of books, workshops and pamphlets for professionals and run public talks and workshops for the general public (Figures 2 & 3).

Cultural adaptations of CBT

A major part of our work is to adapt CBT for use with Chinese populations. To facilitate Chinese professionals and clients to be familiarized with CBT terminologies, we translated the major CBT terms into easily understood Chinese colloquial terms. For example, 'assumption of responsibility' was translated as '攬哂上身' and 'catastrophic thinking' as '大難臨頭'. By understanding these terms, we hope the clients would be more aware of their dysfunctional thought patterns and to find ways of stopping and changing them.

Another adaptation was the development of the 'Five Strategies' (五常法). These five strategies are actually used to deal with the negative automatic response patterns of the clients (Figure 4). These include: awareness of one's physiological responses to a triggering event, thought stopping, self-disputing question, distraction and positive self-statement. There's nothing fancy about these and we did not invent them. What we did create, in this regard, is to make it into a structure so that our clients can easily remember them. Indeed, this presentation fits the cultural characteristics of Chinese people who prefer counselling to be structured and practical.

Findings of our CBT studies for Chinese people

This is a summary of the studies that we did since 2006 and I want to briefly go through the findings with you (Table 1). Many of these studies had good results with moderate effect sizes. For "effectiveness" studies using community samples, the results were quite encouraging. Quite a few of the studies had a follow-up test, although most of them could only be done with a quasi-experimental design. True randomization was not possible as some agencies and frontline workers did not feel comfortable in not responding immediately to the needs of their clients.

Specifically, for depression, the results appear to suggest that CBT may be effective for the depressed Chinese. Some studies looked at clinical significance, using a statistical approach. For example, in one study, we did find the improvements to be quite encouraging - 40% completely recovered and outside of the clinical range. In our latest study on depressed Chinese commissioned by the Mental Health Association of Hong Kong, some improvements were noted in CBT for people with depression and anxieties, particularly for anxiety groups with quite a few significant positive changes.

Figure 2: Training manuals and materials and books

Figure 3: Members manual, Group materials and worksheets

Figure 4: Group materials used

Table 1
Summary of CBT studies from 2006 to 2013

Year	Target group	N	Experimental design	Program (duration)	Major significant results: CBT vs. Control groups, or, Change within CBT group	Effect size (Cohen's d)	Clinical Recovery
2006	Patients with social anxiety	17 vs. 17	Randomized wait-list control Pre-, Post-tests	Group CBT (10 weeks)	↓ social anxiety ↓ dysfunctional rules ↓ negative emotions ↑ adaptive coping skills ↑ positive emotions	0.93 0.66 0.83 0.63 0.52	N/A
2007	Patients with depression	48 vs. 40	Randomized wait-list control Pre-, Post-tests	Group CBT (10 weeks)	↓ depressive symptoms ↓ dysfunctional rules ↓ negative emotions ↑ adaptive coping skills	0.76 0.88 0.59 0.57	39.6% improved
2008	Patients with major depression	163 vs. 159	Randomized wait-list control Pre-, Post-tests,	Group CBT (10 weeks)	↓ depressive symptoms ↓ dysfunctional attitude ↓ perfectionism-high standards ↑ quality of life	0.74 0.44 0.32 0.61	7.4% recovered 19.7% remitted 45% improved
2009	Patients with depression	18 (from 2007 study)	***Only CBT group** Pre-, Post-, **Follow-up** tests	6-month follow-up	Continue to maintain at follow-up: ↓ depressive symptoms ↓ dysfunctional rules ↑ adaptive coping skills ↑ positive emotions	 0.76 0.77 0.54 0.59	At follow-up: 27.7% recovered 33.3% remitted 33.3% improved
2013	Pregnant women with depression	47 vs. 50	Intervention vs. wait-list control Pre-, Post-tests	CB program trial run (6 sessions)	↓ depressive symptoms ↓ perceived stress ↑ satisfaction with family functioning	0.24 0.20 0.19	
2013	Patients with depression (at least mild depression)	11 ^	***Only CBT group** Pre-, Post-, Follow-up tests after 6 months	Group CBT (8 weeks)	↓ depressive symptoms after intervention * The improvement in depression did not sustain after 6 months	0.68 (Pre- and posttest only)	
2013	Patients with anxiety (at least mild anxiety)	14 ^	***Only CBT group** Pre-, Post-, Follow-up tests after 6 months	Group CBT (8 weeks)	↓ severity of anxiety after intervention ↓ dysfunctional attitude ↑ QOL (overall, psychological health, and total score) * All improvements sustained after 6 months (similar effect size), in addition, a delayed improvement was observed for physical health in QOL measure (Cohen's d = 0.65)	0.60 1.08 0.58-0.82	

^ Out of 18 participants who attended at least 4 sessions of the CBT groups

Reflections

The Beckian frameworks of depression and anxiety appear to be applicable to Chinese. With appropriate adaptations, the frameworks are understood easily by our professionals and clients. Particularly, many professionals in Hong Kong like to learn techniques and CBT offers rather concrete and practical techniques that can be easily used with clients. But let me remind colleagues sitting here that while techniques are useful, it is more important for professionals to learn to properly engage in case formulation before adopting certain CBT techniques in working with their specific clients.

Translating Western concepts into locally understood language is an important step in the adaptation process. I am particularly fortunate and grateful to have different agencies who have co-developed with me the CBT concepts and different manuals in Chinese. We are in the process of developing a few other manuals on CBT for psychosis, adolescents with anxieties and recovery based CBT approach. CBT is a very systematic and structured approach with practical steps in intervention. This is well-suited to the Chinese who prefer counselling process to be structured and practical. One important aspect of the therapy focus is to engage the depressed Chinese clients to examine their family rules and culturally laden values which may have contributed to their depressive conditions. It helps the clients to become more flexible and adaptive in their long-held values and attitudes.

As I said in the beginning of this speech, 'gaining new experience' is an important component of the therapy process. Chinese clients seem to learn more, not through logical deductions, but through experiences and actions. By engaging in actions and new experiences, Chinese clients are able to collect evidence to support or refute their beliefs. Thus, we use a lot of behavioural experiments rather than Socratic questioning when working with our clients. We encourage our clients to experience something different and then help them debrief those experiences so that they can examine their thoughts and behaviours. Another related idea when working with Chinese people is to stress on the functionality of a thought and behaviour rather than focussing on the 'correctness' of a thought or behaviour. While this can minimize unnecessary debate with your clients about certain thoughts and actions, this can actually increase Chinese clients' motivation for change if they can see the practicality of the issues involved (e.g. changing my thought can make myself and my daughter happier).

As I said before, another important point about CBT is the long-standing debate about emotions. 'Emotion' is an important part of my CBT work. To me, 'emotion' is a good anchor for relationship building with one's clients. It also forms the basis for facilitating our clients to challenge their behaviours and to engage in behavioural experiments and behavioural changes. However, we do find some Chinese clients lacking the vocabulary and sensitivity towards their emotions and it is important to develop strategies to help them become more aware of their feelings and learn to label their feelings more accurately.

Lastly, we do find manualized group CBT useful and professionals and clients seem to like to learn through the manuals. However, there are still a lots of questions to be resolved. How many sessions constitute a standard and good protocol for a particular disorder? Do eight, ten or twelve sessions constitute a good protocol? What sorts of exercises or worksheets should be included in the protocol? What strategies should we use? From a research point of view, there are still a lot of unanswered questions particularly in relation to their applications for Chinese. When hearing the works of other colleagues using different

approaches in working with people with depression and anxieties, I cannot help but to think that there is a need to integrate other approaches and CBT in order to maximize the therapeutic effects on our clients. What are the other approaches that best fit together with CBT? Dance or art therapies or others? More work is needed to be done in the area of therapeutic integration. However, one thing I can be more certain about, no one single therapy can work for all clients. Even though I am a proponent of CBT, I am very aware that we have to learn from other therapies when working with clients with depression.