Collaborative Empiricism in Culturally Sensitive Cognitive Behavior Therapy

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Collaborative empiricism, one of the main tenets of cognitive behavior therapy, could encounter conceptual and practical problems when applied to culturally sensitive settings. This paper sets out to discuss issues in applying collaborative empiricism to Chinese patients, taking into account a number of cultural determinants such as collectivism, hierarchical perception, passivity, reticence, and superstition. These will be discussed in light of studies on the impact of Chinese culture on patient behavior. Evidence on the successful application of cognitive behavior therapy to Chinese patients will also be presented. There is a pressing need for culturally sensitive clinical procedures and skills adaptation. A case study is presented to illustrate how culturally mediated resistance in collaborative empiricism can be overcome by good clinical practice.

Therapeutic relationship is often held to be the chief “common factor” of all models of psychotherapy. It has been found that therapeutic alliance is positively related to change in various types of psychological interventions (Gaston, Marmar, Gallagher, & Thompson, 1991; Morgan, Luborsky, Grits, Christ, Curtis, & Solomon, 1982). Such findings have been taken to suggest that therapeutic alliance is often a sufficient agent for change in effective psychotherapy. Orlinsky, Grawe, and Parks (1994) suggested that it is probably the decisive determinant of therapeutic effectiveness.

To enhance therapeutic relationship, qualities of empathy, warmth, and genuineness in counseling and psychotherapy have long been accepted as the central attributes of an effective therapist (Heslop, 1992). However, A. Beck, Shaw, Rush, and Emery (1979) regarded the core conditions of empathy, warmth, and congruence as necessary, but not sufficient, for change in cognitive therapy. They also suggested that a collaborative relationship in which the therapist has considerable skill and expertise to be a further necessary factor. Such a view was further buttressed by Feeley, DeRubeis, and Gelfand (1999), who found that towards the latter half of therapy, the level of therapeutic alliance was predicted by the amount of prior symptom improvement, not vice versa, as implicated in earlier writings.

A. Beck et al. (1979) emphasized that in cognitive therapy, the therapist and the patient should ideally form a team that unites and works together to solve the key problems. In this respect, A. Beck and Emery (with Greenberg; 1985) commented on the different but interlocking roles between the therapist and the patient:

The cognitive therapist implies that there is a team approach to the solution of the patient's problem: that is, a therapeutic alliance where the patient supplies raw data (reports on thought and behavior ...) while the therapist provides structure and expertise on how to solve the problems. The emphasis is on working on problems rather than on correcting deficits or changing personality. The therapist fosters the attitude “two heads are better than one” in approaching personal difficulties. (p. 175)

J. Beck (1995, p. 8) also made the point that “cognitive therapy emphasizes collaboration and active participation,” and regarded it important that the therapist and the patient should work collaboratively in agenda setting, session reviews, homework assignments, and making frequent summaries. In the process, both the therapist and the patient will collect data and information pertaining to the way they construe and conceptualize the problems. This can only be done by examining the information experientially, objectively, and empirically.

Thus, collaborative empiricism involves treating patients as informed consumers and providing them with information about their illness. J. Beck (2011) remarked that therapists do not generally know in advance to what degree a patient’s automatic thought is valid or invalid. Using the process of collaborative empiricism, the therapist and the patient can work together to test the patient’s thinking and to develop more helpful and accurate responses. A. T. Beck,
in his foreword to the second edition of *Cognitive Behavior Therapy: Basics and Beyond* (J. Beck, 2011, p. xi), observed that a number of participants in clinical trials could, at times, go through the process of cognitive therapy without any sense of the principle of collaborative empiricism. The current paper sets out to examine the definition of this important therapeutic ingredient in cognitive behavior therapy, and discuss how it operates in a culturally sensitive setting, specifically, working with Chinese patients.

**Collaborative Empiricism**

**Collaboration**

Padesky (2004) suggested that collaboration can be understood as “an equal working relationship.” DeRubeis, Tang, and Beck (2001) also made the point that there is a collaborative relationship between the therapist and the patient to assume an equal share of the responsibility in solving the patient’s problems. Moreover, the patient is assumed to be the expert on his or her own experience and on the meanings he or she attaches to events. In other words, the cognitive therapist does not assume that he or she knows the “what,” the “how,” and the “why” of the patient’s cognitions and feelings. Instead, both the therapist and the patient should work collaboratively to arrive at the answers. Although cognitive therapy can be quite directive, proper respect for collaboration prevents any tendency toward authoritarian practice. In light of these arguments, it is often assumed that collaboration entails an “equal” share of commitments and responsibilities in the therapy process.

However, there are doubts as to whether the working relationship can be truly “equal.” Freeman and McCloskey (2003), for example, suggested that collaboration need not be always 50:50. It may be 70:30, or even 90:10, in which case the therapist will be providing most of the energy or work within the session. This is particularly evident in severely depressed patients. In a depressed patient, for example, the energy level may be low, and it may be necessary for the therapist to do something upbeat in the first instance rather than working under the assumption of an “equal” responsibility. Thus, collaboration is something that has to be developed, not assumed. It is also something that is dynamic rather than static. When the patient is at a low energy level, or is uncooperative or disengaged in therapy, the therapist will have to work around the resistance by taking the lead. This can be done through suggestions, challenges, realigning treatment goals, Socratic questioning, or even through more didactic approaches such as psychoeducation, proposal of a problem formulation, or other behavioral maneuvers (J. Beck, 2005; Leahy, 2001, 2003).

Young and Beck (1980) clearly defined collaboration in their *Cognitive Therapy Rating Scale Manual*, stressing that good collaboration ensures compatible goals between patient and therapist, minimizes patient resistance, and prevents misunderstandings (Young & Beck). J. Beck (2011) further enumerated a number of review questions to ascertain the level of collaboration between therapist and patient. For example, “Have the patient and I truly been collaborating? Are we functioning as a team? Are we both working hard? Do we both feel responsible for progress?” (J. Beck, p. 350). Such questions are useful operational guidelines in therapy to ensure appropriate compliance to effective collaboration.

**Empiricism**

While the concept of “collaboration” has been mentioned on many occasions (A. Beck et al., 1979; J. Beck, 1995, 2011; Young & Beck, 1980), “empiricism” is rarely defined, and is therefore more complex to conceptualize. In everyday usage, empiricism refers to methods based on observation or experiment, not on theory. To the cognitive behavior therapist, empiricism is a process by which patients are skillfully guided to discover their automatic thoughts, assumptions, behaviors, triggers, and maintenance factors. It also furnishes the patient with alternative experiences based on personal observation, thus providing them with extra or competing data to facilitate reevaluation of their core schemas (i.e., their original “theory of the world”).

However, personal experience, no matter how piecemeal or incidental, could, in the eyes of the person, constitute a piece of powerful “empirical” evidence. A twiddle of the ear prior to winning a hand of blackjack could be empirical evidence to the person that the behavior is a necessary precursor to a favorable outcome, although it could be dismissed as a superstitious behavior (Skinner, 1974). Going around the block to avoid a certain street corner where a person was robbed the week before could be, in the experience of the person, an empirically proven maneuver to ensure safety in the future, although many cognitive behavior therapists would regard it as avoidance or as a maladaptive safety behavior (Salkovskis, 1985).

Perhaps the key issue lies in the idiosyncratic understanding of “empiricism” in the individual. Sadly, the appreciation of empiricism is never universal. Common folklore, beliefs, and myths often stemmed from the uncritical acceptance of superficial, incidental, and insufficient data. To the person, however, these are empirical data nevertheless. This issue is even more acute when an ethos of superstition is implicit in a culture. Empiricism therefore entails not “what” data to take, but “which” data to take and “why” such data should be taken. To be able to dispel old beliefs on the bases of new observation and experience, the person needs the basic tenets of a scientific mind entailing the basic concepts of objectivity and probability.

Implicit in the process of collaborative empiricism in cognitive behavior therapy is the quest to steer a patient
away from subjective distorted beliefs based on insufficient data to objective observations based on more realistic facts. It is through this subjectivity-to-objectivity pathway that the cognitive behavior therapist could help the person to snap out of superstitious beliefs, or to stop engaging in futile safety behaviors. However, the concept of empiricism as it stands does not implicate a distinction between what is subjective versus what is objective. Moreover, there is little mention in the cognitive behavior therapy literature as to how empiricism is operationally defined, and how empiricism can be enhanced. Unlike collaboration, there is little objective measure as to how successful empiricism has been attained in therapy.

The following section will examine the application of cognitive behavior therapy to a culturally sensitive population, the Chinese. The dimensions of collaboration and empiricism will be discussed in the light of the Chinese cultural context.

**Cognitive Behavior Therapy for Chinese Patients**

**Chinese Culture and Psychological Treatment**

Sue and Sue (1990) posited that theories of counseling and psychotherapy represent a variety of worldviews that may clash with the worldview of the culturally different client in terms of values, biases, assumptions about behavior, language, and constructs. This may be the case when psychotherapy is applied to Chinese patients. The importance of cultural sensitivity in counseling and psychotherapy has been reviewed in a number of studies pertaining to the Chinese (Cheung & Chan, 2002; Leong, 1986; Lin, 2002).

Leong (1986), for example, reviewed the therapy process of American-Asians and suggested that Asians (Chinese people included) tend to have less tolerance toward ambiguity and prefer structured therapy sessions with practical and immediate solutions to their problems. Cheung and Chan (2002) furthermore suggested that Chinese patients are not used to expressing their emotions openly and in a free-flowing manner, and may require a more structured and focused format in order for them to express their feelings.

In line with the observation that Asian patients have less tolerance for ambiguity, Lin (2002) found that cognitive behavioral therapy is effective for Chinese people because the therapy can be carried out in a structured and systematic format that emphasizes the step-by-step uncovering and learning of new cognitive and behavioral skills. It was also found that Chinese patients perceive their group leaders as effective when they take partial responsibility for the process and play an active role in providing suggestions and advice. It was further argued that Chinese patients expect the therapist to be active in the therapy process and be able to provide concrete and practical advice that offers immediate solutions to their emotional problems (Lin).

In summary, these authors have alluded to some of the salient cultural characteristics of the Chinese: collectivism, hierarchical class delineation, lower levels of verbal and emotional expressiveness, and a yearning for unambiguous, structured and clinician-led therapies that are short-term and solution-focused. All the above factors are seen to be important in maximizing the benefits of therapy.

**Importation of Western Psychotherapy Into China**

In the early 1980s, Western psychotherapies found their way into China. These included psychoanalysis, dynamic psychotherapy, Jungian psychology, person-centered therapy, and structural family therapy (Chang, Tong, Shi, & Zeng, 2005; Qian, Smith, Chen, & Guo, 2002). However, there was little attempt to take into consideration culturally sensitive issues in counseling and psychotherapy as espoused by Leong (1986) and Sue and Sue (1990). From then until now, there have been moves on three different fronts in the practice of psychotherapy in China: theoretical integration, development of indigenous treatment approaches, and eclecticism.

The Chinese are staunch believers that the best option is to integrate different theoretical paradigms as a quest to reap the best ingredients out of quite diversified treatment approaches. One example is cognitive insight therapy developed by Youbin Zhong (Qian et al., 2002), which remained largely a theoretical postulation than an empirically supported procedure. Another attempt was to weave Chinese Taoist philosophy into the premises of cognitive therapy, resulting in a branch of indigenous treatment approach called Chinese Taoist Cognitive Psychotherapy (Zhang et al., 2002). Furthermore, there is a prevailing ethos in China to adopt an eclectic approach in psychotherapy. Clinicians simultaneously use quite diversified therapeutic approaches on the same patient in the hope that good will be done on all fronts. The phenomenon has also been described as “a thousand flowers bloom” (Chang et al., 2005). Unfortunately, eclecticism was practised without due consideration of theoretical eclecticism versus technical eclecticism as cautioned by Lazarus (1967).

Although behavioral and cognitive therapies were first introduced to China in the late 1980s (Ji & Xu, 1989; Qian & Chen, 1998; Xu & Ji, 1996), the development of cognitive behavior therapy in China was hampered by a lack of translated textbooks, learning materials, trainers, and supervisors at the time. It was not until the last decade that there was a steady increase of systematic training programs to introduce cognitive behavior therapy to China (C. Wong, 2011; C. Wong & Ng, 2010, 2012). Chinese patients favored behavioral approaches over psychoanalytic approaches. The behavioral approach, perhaps more synergistic with traditional Chinese culture and philosophy, appealed to the Chinese patient for its didactic, systematic,
outcome-focused, and time-limited nature (Chang et al., 2005; Lin, 2002).

Following the introduction of cognitive behavior therapy into China, and the application of cognitive-behavioral procedures to Chinese patients worldwide, a number of discussions ensued questioning the cultural fit of cognitive behavior therapy to Chinese patients (Chen & Davenport, 2005; Hodges & Oei, 2007; Lin, 2002). It has often been argued that Western treatment modalities cannot be transposed en bloc cross-culturally, and some form of cultural adaptation will be needed. F. Wong, Chau, Kwok, and Kwan (2007) attempted to indigenize cognitive therapy for the use of Chinese patients in Hong Kong. This involved the adaptation of alternative colloquial terms that may make more sense to Chinese patients, such as using the term “thought traps” in place of “automatic thoughts” (F. Wong, 2010).

The mode of treatment protocols aside, the following cornerstone questions still remain: How receptive are Chinese patients to cognitive behavior therapy? Is there collaboration between therapist and patient? Is it possible to align a mutually agreed treatment goal? Are patients willing to partake in behavioral experiments to see for themselves whether real-life observation will occur as predicted? In other words, are Chinese patients capable of being collaborative as well as empirical?

**Collaborative Empiricism: Lost in Translation**

Translation of English technical terms into Chinese is more complex than one would imagine. There is no universally agreed upon thesaurus between the two languages, and translation often results in a conceptual, sometimes idiosyncratic, interpretation of a term’s meaning. The situation is further complicated by different terminologies in psychology and psychiatry between Mainland China and Taiwan, both using Chinese as the root language. Even within Mainland China, there are various translations of the same technical term, resulting in frequent confusion and inconsistencies within the academic literature.

“Collaboration” is often translated as “cooperation” in the Chinese language, which, although not entirely incorrect, has lost some of the flavor of the original English word. As suggested by Freeman and McCloskey (2003), someone can be cooperative without agreeing on the basic theoretical premise. Indeed, one can be cooperative but do so in a disinterested or even perfunctory way. Recently, one translation of collaboration added a flavor of “assisting” on top of “cooperation.” Another translation alludes to a “partner relationship.” None of these, however, is a perfect translation of “collaboration,” but at least there are continuous attempts toward improvement.

Translation of the term “empiricism” into Chinese is even more challenging. A literal translation is “the doctrine (principle) of evidence proof.” One Chinese translation alludes to “down-to-earth information.” It is obvious that various translations would give rise to differing interpretations and understanding of the term. Recently, some workers translated “collaborative empiricism” into “cooperative practice” (Li, personal communication, November, 25, 2011), which may still be insufficient to reflect the core essence of the term.

**Collaboration in Chinese Patients**

There exists a collectivism-versus-individualism distinction between the Chinese and their Western counterparts, with the belief that the Chinese are less individualistic and hence less willing to express wishes and opinions that digress from social and authoritative values. It has also been posited that traditional collectivist culture is still very much part of the Hong Kong scene (Cheung & Chan, 2002). A tendency toward collectivism may also imply that in therapy, Chinese patients may be more inhibited in volunteering individual opinions. Writers have also observed that Chinese patients are passive and submissive, expecting their doctors to be directive and authoritative (Hodges & Oei, 2007; Lin, 2002). However, it could also be argued that the cultural traditions of class distinction and status/hierarchy are factors in Chinese patients’ complacency and cooperation in the cognitive behavior therapy process.

The practice of cognitive-behavioral therapy with Chinese clients has been well-documented, and therapists in general have not reported serious process impediments (Foo & Kazantzis, 2007; Lin, 2002; Ng, 2008; Qian & Chen, 1998; F. Wong, 2010, 2011; F. Wong et al., 2007; Xu & Ji; 1996). For example, Foo and Kazantzis reported that Chinese patients were highly compliant with homework assignments because, culturally, homework has been construed as an essential learning process and a useful learning tool. Successful application of cognitive behavior therapy to patients with depression or anxiety in a group setting yielded encouraging results (F. Wong, 2007, 2008, 2009). The only onus is that, in the above series of group cognitive behavioral therapy sessions, Chinese participants reported outpouring of negative emotions counterproductive to the treatment process (F. Wong, 2011). This further reinforces the thesis that the Chinese are more reticent in therapy sessions than their Western counterparts (Cheung & Chan, 2002).

In working with Chinese patients, collaboration can be challenging because of the hierarchical status perception inherent in the Chinese culture. The patient often expects the therapist to have all the answers and believes there is no need to do any work in the guided discovery process. Many Chinese patients would ask the therapist about an opinion on the genesis of their problems. C. Wong and Ng (2012) considered that upbringing in traditional Chinese medicine...
might have prompted a strong belief of cause-and-effect relationships. It is not uncommon for patients to inquire about the underlying “cause(s)” of problems, believing that every problem must have a cause. They also believe that once the root of the cause is known, solution will follow. To a point, cognitive therapy can offer a form of causal explanation—that emotional ailments are the results of irrational and dysfunctional beliefs (C. Wong & Ng). The proposition of core schema in determining thinking styles is also welcomed and readily accepted. Ng (2008) found that Chinese patients are particularly receptive to sharing case formulation, wherein “theory, research, his or her own problems as well as personal strengths were concocted in a crucible” (Kuyken, Padesky, & Dudley, 2008).

Empiricism in Chinese Patients

The traditional Chinese folklore is laced with myths and belief systems. These include god-worshipping, burning offerings to ancestors, fortune-telling, alternative remedies, and other superstitious practices. One way of illustrating this superstition versus empiricism dilemma is by way of a common Chinese belief called feng shui. Feng shui is a superstitious belief that arranging furniture and household items in certain specified ways will alter the surrounding field energy to ensure luck, wealth, and prosperity. Fortune tellers and feng shui experts have become very prosperous in a Chinese society. Firm believers of feng shui can get so entrenched in the theory that they would eschew any suggestion that might prove to them otherwise. To them, the fact that their family is safe and happy is sufficient empirical evidence that feng shui is really working. Hence, it will be unlikely for them to get involved in any experimental attempts to test out if there is a true relationship between wellness and furniture arrangement. At the backdrop of such unscientific and superstitious ethos, one would anticipate that Western empiricism will be doomed to rejection by Chinese patients.

Indeed, if one traces the 5,000 years’ history of China, objective science, research, and the concept of empiricism are not main tenants of the culture. The feudal system bred a tradition of collectivism, bringing up children with a strong indoctrination of filial piety instead of encouraging inquisitiveness, skepticism and individualism. The education system rarely fosters the importance of a critical mind, as knowledge and wisdom are handed down from generation to generation. It is no wonder, therefore, that the average Chinese worldview is often based on incidental observations, piecemeal evidence, hearsay information, culturally determined collective beliefs and superstition. The fact that psychotherapy in China has, for decades, been leaning towards uncritical acceptance of convenient importations from the West without due consideration of empirical evidence may be a good testimony to this observation.

However, the Chinese are known for their practicality and pragmatism. An axiom from Deng Xiaoping, late leader of China, dictated, “I don’t care if it is a white cat or a black cat—the cat that catches mice is a good cat.” It is also interesting to note that in the Doctrine of the Mean, taken from the classic teachings of Confucius, wisdom ingrained in the five processes of knowledge acquisition conforms with the basic tenets of empiricism:

1. To learn widely.
2. To ask inquisitively.
3. To think carefully.
4. To argue wisely.
5. To practice wholeheartedly.

In our clinical practice, we do encounter numerous examples of superstitious beliefs, jumping to conclusions, and yearning for immediate and magical remedies. The challenge in creating a culturally sensitive cognitive therapy setting is to take heed of such distorted beliefs and expectations and to instigate an insidious realignment to fact and objectivity through the process of collaborative empiricism.

Collaborative empiricism, in the context of this paper, thus calls for sensitivity to culture at the beginning of therapy, as well as good clinical skills during the course of treatment. Patients may need to be guided towards reevaluation of their prevailing beliefs, and to learn to initiate objective and rational dialectics with their core beliefs. Ng (2008) observed that it might take more than 8 to 10 sessions before a Chinese patient can become accustomed to a collaborative stance. The process, nonetheless, helps in building greater trust before such an “unconventional” working style could be safely accepted in the therapeutic relationship.

Case Example

Choice of Case Study

The following case study illustrates engagement and collaboration. Some of the difficulties in this case probably stemmed from the patient’s traditional beliefs that the therapist is an all-knowing, omnipotent expert who will “cure” the patient. Cognitive therapy was also hampered by the patient’s limited participation in collaborative work such as agenda setting, guided discovery, and behavioral experiments. There was also poor adherence to homework assignments. Another roadblock was the patient’s firm conviction about her own theory of the mind, and was hence reluctant to partake in behavioral experiments set out as homework assignments. As the therapy progressed, the patient agreed to try out in-vivo behavioral experiments on the condition that she was being accompanied by the therapist. When experiential observations were contrary to the patient’s initial predictions, cognitive changes took
place, which, in turn, expedited the progressive remission of the core symptoms.

Background Information

Josie was a 38-year-old unemployed single female who came from a wealthy family. She was referred to the clinic by her attending psychiatrist. Her intake information sheet indicated, “Hope to overcome my fear towards other people and to reestablish normal interpersonal relationships.”

Josie was guarded in the initial interview and was unwilling to disclose details of her family members. The only information that Josie revealed was that, at the age of 12, her father left the family for a Thai woman, and she has not seen her father since that time. This happened after over 15 years of strained marital relationship with Josie's mother. At this juncture, establishing a good therapeutic alliance involved not pressing Josie for more information, but to be sensitive that Chinese patients could feel shameful and guilty in psychotherapy. Sensing her reluctance, the therapist resumed the interview by focusing on presenting problems with genuineness, concern, understanding, and a professed willingness to help.

When the conversation topic was changed, Josie became more spontaneous and animated. She described her chief complaint as “feeling anxious towards middle-aged women.” She said that she could trace her problems back to her all-girl secondary school run by nuns. Her classmates were snobbish and would not play with her. She then went to Canada for university but did not manage to finish her studies. She went back to Hong Kong and attempted an associate degree course but again dropped out of college. Josie also remembered being teased and ridiculed by her aunt for her academic failures.

At the age of 27, she had her first episode of psychosis with vivid auditory hallucinations. Her family doctor referred her to a private psychiatrist whom she has been seeing for the past 10 years. Her illness remitted with medication, and she is currently well-maintained by regular psychiatric follow-ups. She has not had any auditory hallucination for over 5 years.

After the resolution of her psychotic episode, she started to develop a fear of women, especially those in the age range of 40 to 50. She stated that middle-aged women are “dirty and mean” because “they have lost the virility and their bodies are sagging.” She also believed that middle-aged women would use surreptitious tricks to extort money from her. They would always pick her out from the crowd because they know she is rich. They would approach her and would attempt to chat her up. They would then ask her for money, which they would never return. Moreover, she thinks middle-aged women are all infected with diseases and would pass the germs onto her. In the case of Josie, it is important to show adequate and appropriate understanding of her “internal reality” (Young & Beck, 1980), and to be mindful that her complaints could be part and parcel of her residual psychotic symptoms.

Josie reported that this fear had intensified in the past years, and she has virtually been living the life of a recluse. About 3 years ago, she asked her family to buy her an apartment so that she could live by herself. She was also being provided with a chauffeured car. Every afternoon, she would go to the gym for 3 hours during which time a domestic worker would go into her flat to clean up and to prepare meals. She rarely went out and her social circle was restricted to a handful of close friends whom she could ring up or connect via Skype. Recently, she agreed with her psychiatrist’s suggestion that she should seek therapy from a clinical psychologist for her fear of people and increasing social isolation.

Therapeutic Goals and Initial Treatment Attempts

Apart from being reticent about her family background, Josie was quite talkative, with no sign of any anxiety or social inhibition. She explained that she has no problem with men because they are not as unscrupulous as women. The therapist and Josie quickly agreed on a common treatment goal: to overcome her fearful attitude toward middle-aged women. When it was suggested that she should work closely with the therapist to understand more of her problems, she replied, “I was told that you are the expert and you should know all the answers.” When it was suggested that the therapist might need her assistance in order to understand the true extent of her problems, Josie retorted, “When I see doctors with my mother, they always have answers and explanations.” The therapist then suggested that he might have the answers, but he needed her help to check out if the answers are 100% correct. To this, she replied, “You are the expert, and it is for you to judge. Just tell me what is wrong with me and how I can get rid of this fear.” It was apparent, at this point in therapy, that Josie was upholding a strong hierarchical patient-therapist role delineation, and expected that the therapist would be taking a directive and leading role in treatment.

The first session concluded by attempting to give Josie a homework assignment. She was asked to record incidents in which middle-aged women (a) take notice of her, (b) approach her, (c) chat her up, and, (d) ask her for money. However, Josie came to the second session empty-handed and told the therapist that she had not done her homework. The therapist decided to forgo insistence on homework assignments lest the therapeutic relationship weaken.

In Session 2, an attempt to set an agenda “to talk more about the dangers of middle-aged women” was met with a counterproposal that therapy time would be better utilized in getting rid of her fears. This is a common request among
Chinese patients as they tend to be more problem-focused, and, at the same time, seek quick, magical cures. Engagement through talking about her irrational thoughts and beliefs proved to be a slow process.

Better rapport was established when questions were phrased along Josie’s beliefs and convictions. For example, the therapist asked her to describe one example of a middle-aged woman she saw in the gym. To this, Josie suddenly became more engaged and animated, and started a running account on the woman’s hideous body and the mean looks on her face. Along a similar line of approach, Josie slowly agreed to play a game of “How to identify dangerous women from benign women” using pictorial magazines. With such a concrete exercise, the level of collaboration with Josie started to improve.

In the ensuing therapy sessions, attempts to ask her to critically evaluate the reality of her perception of middle-aged women and evidence supporting her assertions were met with blatant refusal. When it was suggested that Josie stood on the pavement for 5 minutes and see what happens, she remarked, “You are not me, and you don’t know how dangerous those women are.” Also, Josie said that she would not risk having women approaching her and extorting money from her. She was adamant in her belief that women are dangerous, citing firsthand experience from her classmates and her aunt that women are unscrupulous and hurtful. For Josie, previous experience had become her own “empirical evidence” that her fears were amply justified.

Treatment Sessions

It was then decided that therapy should move to a more behavioral paradigm. In Session 5, the therapist decided to take advantage of Josie’s preference for status and hierarchy by proposing that she experience the role of an all-knowing expert by helping the therapist gain first hand information by proposing that she experience the role of an all-knowing expert by helping the therapist gain first hand information on the dangers of middle-aged women. Instead of staying in the clinic, the therapist decided that the most “efficient use of time” (Young & Beck, 1980) was to have in-vivo exposure sessions with Josie. Somehow, Josie found this an amusing idea and agreed that she could help to educate the therapist. After considerable nudging and coaxing, Josie finally agreed to go with the therapist into the street to prove to the therapist that middle-aged women are intrusive and unscrupulous. Josie’s initial apprehension was allayed by the therapist’s gentle but confident reassurance that he would fend off any unwelcomed woman trying to take advantage of her.

Session 6 was the first in-vivo session; it took place on a busy pedestrian foot-bridge adjacent to the clinic. Josie’s first task was to stand by the side of the foot-bridge to observe approaching women and to give the therapist feedback regarding the level of threat female passers-by posed. Josie was also asked to make predictions as to how many women would approach her and try to converse with her. After 30 minutes, Josie made the following observations: “I felt as if I was invisible”; “No one took notice of me”; “No one bothered to look at me”; and “Where have those terrible women gone?” During a subsequent debriefing session, Josie began to realize that reality was very different from her predictions: that is, no one bothered to approach her and to chat with her.

In Session 8, Josie was more confident in the behavioral experiment, and agreed to try out something bolder. This time, she was encouraged to randomly approach a woman to ask for the time. Josie made the prediction that once she approached the woman, the woman would start chatting her up and asking her for money. It took a while for Josie to muster up enough courage to approach a passerby. To Josie’s surprise, the woman whom she approached simply gave her the right time and then walked off without any further conversation. Again, Josie was surprised that none of her predictions had come true.

In Session 9, Josie and the therapist stood at the entrance to the local underground where two women were soliciting donations for a charity organization. Josie was encouraged to walk by the women. When she was being asked for donation, she was instructed to simply say “No, thanks!” and then observe what would happen. Josie predicted that the women would nag her into contributing a large donation, Josie came back surprised that when she said “No, thanks!” the women simply replied, “Thank you!” and nothing else happened.

Josie defaulted her next appointment and did not return for follow-up. A call from the psychiatrist 2 weeks later confirmed that Josie was happy with the therapy, and she told the psychiatrist that “middle-aged women are not as frightening.”

Treatment Outcome

The case example illustrates resistance in engagement and collaboration from a Chinese patient with fear of middle-aged women. The phobia could be part and parcel of her remitted psychosis. For 3 years, the patient managed to avoid the feared objects via a reclusive lifestyle made possible by her wealthy family. Conventional protocols of cognitive behavior therapy were met with such roadblocks as reluctance to disclose family information, refusal to engage in a collaborative therapeutic alliance, failure to complete homework assignments, insistence that the therapist should be doing all the work, and harboring a firm conviction of her distorted beliefs based on past experience. The following culturally sensitive maneuvers were deployed: (a) avoid dwelling on topics sensitive to the patient (i.e., family background); (b) encourage elaboration of her fears and transforming the dialogue into action games (i.e., picking out dangerous and benign women
from magazines); (c) acknowledge the patient’s traditional hierarchical belief and turn it into an advantage (i.e., teaching the therapist about the dangers of middle-aged women); (d) use behavioral strategies in lieu of verbal strategies (i.e., accompanying the patient during in vivo exposure); and, (e) help the patient to make sense of new empirical experiences (i.e., encouraging cognitive shifts in light of contradicting evidence collected via behavioral experiments). Successful engagement and improved collaboration resulted in opportunities to assimilate new information. In the end, satisfactory cognitive and behavioral changes were achieved.

**Conclusion**

The application of cognitive behavior therapy should be culturally sensitive in order to adapt to cultural differences. Using collaborative empiricism as a focal point for discussion, culturally specific caveats need to be considered in order to make therapy a success. The hurdles described in this paper may not necessarily be specific to the Chinese culture, per se. Other cultures, even those in the West or in other developed countries may pose similar problems. Therefore, what is needed is not a specific treatment algorithm for a specific culture, but a keen sensitivity on the part of the therapist towards a patient’s worldview. Good clinicians should have innovative ideas and skills to help them negotiate roadblocks in therapy. Good clinical insight and skillful tactical flexibility are the cornerstones of therapeutic success.

With increasing evidence of the applicability of cognitive behavior therapy to Chinese patients, it is perhaps no longer valid to treat the so-called “Chinese culture” as a static phenomenon around which psychotherapies should revolve. Chinese patients can be steered toward collaboration and empiricism via skillful clinical practice (C. Wong, 2011; C. Wong & Ng, 2010). In the light of rapid globalization and shifting values, cultural factors such as traditional beliefs and philosophical convictions will likely be further watered down in the generations to come (Lin, 2002). Experience suggests that ongoing attempts in China towards theoretical integration in psychotherapy are futile. By the same token, the quest for cross-cultural shifts in light of contradicting evidence collected via behavioral experiments). Successful engagement and improved collaboration resulted in opportunities to assimilate new information. In the end, satisfactory cognitive and behavioral changes were achieved.

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Received: January 5, 2012

Accepted: August 14, 2012

Available online 17 October 2012