

## 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, Crits-Christoph, 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,

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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 empirical. 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

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