Development of the Asian Cognitive Behavioural Therapy Research and Practice Network

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Abstract

Although cognitive behavioural therapy (CBT) has been used in quite a few Asian countries for many decades, it has been suggested that a significant barrier for the advancement of research and training in CBT among CBT practitioners has been a lack of a regularized opportunity for networking. This paper presents a brief history of the development of an Asian CBT network. The development of the network started in 1990 (Oei, 1998). Since then, 5 Asian CBT Conferences have been completed successfully; the sixth Conference will be held in Dhaka, Bangladesh, in 2018. In addition, the Asian Cognitive Behavioral Therapy Association (ACBTA) supported by many Asian countries’ CBT groups was also established to provide a firm and durable organization. Formal links with the well-established World Congress Committee (WCC) in Behavioural and Cognitive Therapies were made by requesting ACBTA membership in the WCC. Progress in CBT research, training, and practices has been made in the last few decades. Further progress can and will be made. Asian CBT has started out well in this long journey, and it will end up well.

Key Words: Asian cognitive behavioural therapy (CBT), cognitive behavioural therapy (CBT) practice network, culture, indigenous therapy

Asia is the world’s largest and most populous continent with a rich history involving the development of different cultures, languages, religions, and political systems. Over the last several decades, many countries within Asia have become strong economic powers on the world stage as a result of increased urbanisation and industrialisation (Klonsky et al., 2013). Such modernisation in many regions of Asia has led to greater interactions and importation of Western ideologies and technologies, and thus, substantial social changes. Some of these changes are considered positive, such as better physical health and longer life expectancies; however, there are suggestions that these changes have resulted in a weakening of indigenous cultural values and family and community support networks, a rise in divorce rates, greater alcohol and drug use, and increased

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violence and criminal activity, as well as an increase in other mental health problems, especially depression and anxiety (Klonsky et al., 2013; Nolen-Hoeksema et al., 1992). As a result of these data, as well as data showing that an estimated 60% of the one million suicides recorded globally each year are located on this continent (Khan & Syed, 2011), there has been great national and international interest in improving the mental health of people living in Asian countries. To meet these growing mental health needs, significant advances in this field are required.

In Western societies, mental health problems, such as depression and anxiety, have long been recognised and diagnosed as psychological disorders, such that the first edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM) was created and published in 1952. Since that time, many evidence-based therapies have been developed and applied to treat psychological problems (e.g., Oei, 1998, 2011; Oei & Boschen, 2009; Oei & Dingle, 2008; Raylu et al., 2013). Unlike in Western countries, recognition and treatment of these disorders in Asia did not occur until after World War II (Low et al., 2012). Social stigma, prejudice, and economical and political priorities regarding mental health meant that the development of research, training, and services in this field was given low priority compared to other areas of engineering, medicine, and health (Lesser, 1983). The stigma related to diagnosis and treatment of mental health has decreased over the past few decades, with many Asian governments acknowledging the substantial social and economic burden of mental illness (Nolen-Hoeksema et al., 1992). Although progress in the diagnosis and treatment of mental health problems has been made during this time, evidence-based practices of psychotherapy in many Asian countries are still considered rare (Deva, 2008; Oei, 1998). This is due, in large part, to the limited solid evidence-based research and training in this area, resulting in a severe lack of mental health services and limited use of evidence-based treatments, such as cognitive behavioural therapy (CBT), to aid improvement in psychological wellbeing (Low et al., 2012).

CBT is one of the most widely recognised and used evidence-based psychotherapies in Western society, with an abundance of empirical research demonstrating that CBT is effective in treating a number of psychological disorders (e.g., Beck, 2011; Hofmann et al., 2012; Oei & Dingle, 2008; Wampold et al., 2011). Also, in the West, CBT is widely taught in the education and training of mental health professionals, such as clinical psychologists, psychiatrists, and nurses. CBT has been adapted for use with a diverse set of backgrounds, including different levels of education, income, culture, and ages, and is commonly used in a variety of community as well as inpatient settings. CBT is a structured, time-limited, and person-oriented psychotherapy based on a conceptualisation, or understanding, of an individual's specific beliefs and patterns of behaviour. CBT aims to empower individuals to engage in effective problem-solving about current issues and to modify dysfunctional or unhelpful thinking and behaviour. The theory underlying CBT proposes that dysfunctional thinking influences mood and behaviour and results in psychological distress. To achieve enduring emotional and behavioural change, individuals are taught skills to enable them to identify and challenge distorted and catastrophic beliefs about them-
selves, the world, and others, and to evaluate thought patterns in a more realistic and adaptive manner.

In light of the growing demand to improve the mental health of people in Asia, support for the use of evidence-based therapies, such as CBT, has increased since the 1960's (Nolen-Hoeksema et al., 1992; Turner & Cole, 1994). For example, no CBT study done in Asia between 1965 and 1990 was located that used a randomized controlled design. Since 2009, 10 randomised controlled trials have been published investigating the efficacy of CBT in Asia. This design is considered the gold standard for clinical trials. Findings from these randomized controlled trials studies have suggested that CBT is effective in reducing symptoms related to schizophrenia (Li et al., 2015; Naeem, Saeed, et al., 2015), depression (E. T. Liu et al., 2009; Mukhtar et al., 2011; Naeem, Gul, et al., 2015; Songprakun & McCann, 2012), anxiety (Lau et al., 2010; Sung et al., 2011; Yen et al., 2014), and aggression and rule-breaking (Krishnan et al., 2013) across child and adult populations in individual and group settings.

Despite the increased attention that CBT has received in Asia, there continues to be limited evidence regarding the efficacy of this therapy in Asia, due to a number of significant barriers impeding widespread implementation and systematic research on CBT. The majority of studies in this area has examined these barriers from a cultural perspective, questioning whether CBT principles are compatible with different Asian cultures (e.g., Grant et al., 2003; Hodges & Oei, 2007; Swannell et al., 2014; Voon et al., 2013). Exploration of the utility and validity of CBT across cultures provides valuable information regarding how best to adapt and modify this therapy to meet the therapeutic needs of different individuals more effectively (Castro et al., 2011; Hwang et al., 2008). However, it is also important to explore other barriers that may require more urgent attention, such as those that have the capacity to block the facilitation of more immediate improvements in the use of CBT in Asia. A number of issues has been identified that continue to hinder access of clients to clinicians who are competent in practicing CBT. These barriers include a lack of experienced CBT professionals, research and training networking, teaching and training places, and training resources (Laible et al., 2000; Lesser, 1983; Misra & Rizvi, 2012). If these deficiencies can be overcome, that would aid the development of the skills needed to advance the theory and practice of CBT in Asia and promote research in this area. Advances in CBT knowledge and practice may then aid integration of this therapy into the mainstream of Asian therapeutic culture. It should be acknowledged that culture is also an important barrier, but the lack of education, training, and networking are critical issues that have to be overcome in order to improve the use of CBT in many Asian countries at the present moment. With this in mind, the present paper gives priority to this area ahead of the cultural issue, which is another important barrier. It must be acknowledged here that Asia is not monolithic, but rather full of complexity, and including different ethnicities with differing cultural values. Thus, it is fully acknowledged that different countries or cultures may develop CBT at different rates. We are aware of this limitation in the present paper.

The present paper, therefore, aims to explore (a) the development of research and training networking, and (b) the lack of education and training facilities in Asian countries that are
limiting the development and use of CBT within the field of allied health, specifically from the perspective of clinical psychologists practicing CBT.

CBT is a form of psychotherapy, and is not a recognised and legalised profession. For the purpose of the present paper, the issues are discussed in the context of clinical psychology, given that this is the main profession that uses and promotes CBT. It is also important to consider the barriers through the prism of psychology professionals, because the present paper was written by psychologists for the Asian CBT Association. Nevertheless, it is likely that this discussion can also be applied to other health professions, such as psychiatrists, social workers, and nurses.

Below, the context of CBT training in Asia, relative to the West, is discussed. The identified educational and training issues are reviewed in the context of Asian countries with large populations (e.g., China, India, and Indonesia) which play a significant, worldwide, economic role. Indigenisation of clinical psychology is also discussed in relation to training issues. Before the above issues are discussed, however, a brief history of the development of CBT Asian networking for the benefit of research, training, and practice of CBT is provided.

Development of CBT Networking in Asia: A Brief History

In 1990, the fourth World Conference on Behavior Therapy was held in the Gold Coast, Queensland, Australia. At this conference, the second author took the opportunity to start a movement to develop an Asian CBT network for the advancement and networking of CBT in Asia. A special session, devoted to the examination of the extent of penetration of CBT in Asia, helped to increase awareness of the status of this therapy in this part of the world, and highlighted issues that needed to be addressed. Researchers and clinicians from Asia were invited to participate and present papers at a special session at the conference. The conference resulted in an edited book called *Behaviour Therapy and Cognitive Behaviour Therapy in Asia*, published in 1998 (Oei, 1998). The first chapter of the book set the scene for the application of behaviour therapy and CBT in Asia (Oei & Goh). The next chapter focused on the sociocultural diagnosis of DSM mood disorders in aboriginal Australians (Wooding & Oei). The next few chapters were applications of behaviour therapy in countries such as the People's Republic of China (Qian & Chen), Hong Kong (Tang & Lee), India (Prasadarao), Indonesia (Hadiyono), Japan (Sakano), Malaysia (Singh & Khan), Pakistan (Najam), Singapore (Tan), and Sri Lanka (DeSilva & Samarasinghe), with the final chapter focussing on Thailand (Iansupasit). This book provided a snapshot of the status of the use of CBT in these Asian countries. It also highlighted the limited success achieved, and the barriers encountered at that time.

Following this early movement towards an Asian CBT network, the idea of developing a more permanent networking structure to advance research and training in CBT for Asian mental health professionals for the benefit of Asian people grew stronger. When the second author visited Hong Kong in 2004 for a conference at the Chinese University of Hong Kong and met with Professor Catherine Tang, the Asian CBT Conference was conceived and organized. The first Asian CBT Conference was held at the Chinese University of Hong Kong in May, 2006, attended by more than 400 dele-
gates, mostly from Asian countries. An edited book titled *Current Research and Practices on Cognitive Behaviour Therapy in Asia* was published, based on presentations from this conference (Oei & Tang, 2009). The book consists of 25 chapters, split into three major themes. Specifically, chapters 1–9 focus on current issues in theories and assessment; chapters 10–14, on current Asian psychotherapeutic approaches; and chapters 15–25, on current research on CBT in Asia. The book can be downloaded from [http://www.asiancbt.weebly.com](http://www.asiancbt.weebly.com).

In 2008, the second Asian CBT Conference was organized by Associate Professor Sompc Iamsupasit and his colleagues at the Chulalongkorn University in Bangkok, Thailand. As at the previous conference, more than 300 delegates attended. Abstracts of papers presented can be obtained from [http://www.asiancbt.weebly.com](http://www.asiancbt.weebly.com). In this second Asian CBT Conference, the idea of forming an Asian Cognitive Behavioral Therapy Association (ACBTA), so as to involve more CBT professionals and organizations from Asian countries, was discussed. This idea was supported by the delegates, as it was believed that the formation of such an association would provide firmer foundation for the advancement of research and training of CBT in Asian.

The third Asian CBT Conference, sponsored and organized by the Korean CBT Association and the Korean Psychological Association Clinical Psychology section, was held in Seoul in 2011. Abstracts of the papers presented at the conference are available at the ACBTA website ([http://www.asiancbt.weebly.com](http://www.asiancbt.weebly.com)).

An important milestone at this conference was the formation of the Asian Cognitive Behavioral Therapy Association (ACBTA). The first elected Board members of the ACBTA were the President-Elect, Tian Po Oei (Australia), and seven executive board members: Firdaus Mukhtar (Malaysia), Jung-Hye Kwon (South Korea), Kullaya Pisitsungkagarn (Thailand), Catherine Tang (Singapore), Hiroaki Kumano (Japan), Ning Zhang (China), Sukhanlaya Sawang (Australia), and Young Hee Choi (South Korea). Another important action towards the enhancement of research and training networking was linking up with the well-established World Congress Committee (WCC) in Behavioural and Cognitive Therapies by taking up the Asian membership of the WCC. This improved the ACBTA’s networking ability not only with the WCC but also with national CBT associations around the world.

The fourth Asian CBT Conference, under the banner of the Asian Cognitive Behavioral Therapy Association, was organized in cooperation with the Japanese Association of Behavioral and Cognitive Therapies and the Japanese Association for Cognitive Therapy. The fourth conference was held in Tokyo in August, 2013. At that time, the second author was made President, and Professor Jung-Hye Kwon of Korea University, South Korea, was elected as President-Elect. Abstracts of the papers presented can be obtained from the website of the ACBTA. In this conference, the second group of board members of the ACBTA were elected. The fifth Asian CBT Conference was successfully organized by Professor Ning Zhang and Dr. Chun Wang with the Chinese CBT and Mental Health associations, and held at Nanjing in May, 2015. There were 550 delegates from more than 20 countries participating, with more than 100 scientific papers, 10 keynote addresses, 8 master classes, and three state-of-the-art talks. Professor Ning Zhang of the
Nanjing Brain Institute, China, was elected as President-Elect. President-Elect Professor Jung-Hye Kwon was made President of the ACBTA, with a panel of new board members. The sixth Asian CBT Conference will be organized by the University of Dhaka and Bangladesh Clinical Psychologists Association, and held in Dhaka, Bangladesh, in February, 2018.

Over the last two decades, research, training, and application of CBT have gone through many changes and improvements. Looking at the papers and abstracts from the four CBT conferences, it is clear that Asian CBT research has made huge progress in creating and validating better assessment tools, testing psychopathological theories, and collecting evidence-based treatment outcomes using randomised controlled trials. A preliminary examination of the research papers published in international journals, such as Behaviour Research and Therapy, Psychological Medicine, the Journal of Affective Disorders, and the Journal of Anxiety Disorders, supports CBT progress in Asia. What is most pleasing is that collaborations among nation’s CBT practitioners, and between Asian and Western CBT practitioners, have increased. In addition, the advent of the Asian CBT Conference and later formation of the ACBTA provided an avenue for disseminating ideas, knowledge, and effective application of CBT, and meant that there was a unified network of researchers and clinicians working towards advancing theory, practice, empirical research, and training of CBT in Asia. However, continued development is needed so that Asian CBT can achieve the same status and recognition as the CBT practiced in the West.

Networking and Educational and Training Benefit

In order to ensure continued development of CBT in Asia, it is crucial to have a strong training system that instils a solid foundation of clinical knowledge and skills that are central to practicing different therapeutic methods effectively (Turner & Cole, 1994). To achieve this standard, many Western countries offer training programs in clinical psychology. Completion of a program at the master’s or doctorate level provides accreditation so that clinical psychologists can practice evidence-based CBT, including assessment, diagnosis, and therapeutic treatment of psychological disorders. Many training programs in the West are based on a scientist-practitioner model that focuses on the integration of research and clinical skills, with the aim of helping students make more informed and evidence-based decisions regarding treatment. Although the length of these programs varies across Western countries, they typically involve completion of a four-year undergraduate degree followed by a two-year postgraduate degree that includes a research component and at least one year of practical training as a supervised psychologist. This minimum training program is sanctioned by licensing of the professional. The unified structure of these programs is one of the major pillars for the successful application of CBT in the West. The East, in particular the Asian countries, tend to follow a similar pattern in that an undergraduate and postgraduate degree in psychology is offered. However, there has not been a unified clinical psychology educational and training program that leads to licensing clinical psychologists to practice. Some of the major difficulties are the nature of the content
knowledge, research components, practicums, and supervision hours required.

The structure of clinical psychology training programs in Japan differs widely, with different psychological associations mandating different requirements for entry into their profession. For example, the Japanese Certification Board for Clinical Psychologists requires the completion of a master's degree, including a minimum of one year supervised practice, final exam, and interview, as well as a research project. However, certification from the Japanese Psychological Association requires a bachelor's degree focusing on academic psychology. Training programs also differ across Indian universities with regard to the number of practicum hours needed to complete a master's degree (Misra & Rizvi, 2012; Sarwono, 2004). Some universities do not require practical training, whereas others require two years of supervised practice. Course content also varies across universities, but is typically the main focus of these programs. A similar trend was found in Pakistan (Bersoff, 2008). Students undertaking clinical training in this country often complete two postgraduate master's courses. The first focuses on building a theoretical knowledge base, whereas post-master's degree programs focus more on practical application of the theories and research skills. Furthermore, the amount of supervised practice varies considerably between universities, and is even not offered at all at many institutions. Another example is in China, where applied psychology training programs differ widely in different regions of the country. The clinical psychology training program in Hong Kong follows the Western format closely, and thus is well established and recognised. More recently, Macau has emulated Hong Kong's tradition. It is different in mainland China, where clinical psychology training programs are still in their infancy (Zhang & Xu, 2006). Lack of an agreed-on minimum number of practicum hours and lack of proper supervision are some of the important major barriers.

In general, clinical training in Indonesia and Bangladesh encounters similar barriers as in mainland China. Without unified training programs, all clinical professionals do not have the same level of theoretical knowledge, empirical research skills, and clinical skills. It is, therefore, concerning that although the level of competency may differ, these individuals are working with similar populations of clients without a reliable method of discerning which of the psychologists are adequately qualified. This contributes to a variable standard of psychological practice in which benefits to clients may be minimal, while risk of harm may be increased. Similar to the other training issues discussed, the lack of unified training programs further obstructs the development of this field and, in doing so, negatively impacts on the opportunity to improve the use of CBT in Asia.

Indigenous CBT Knowledge and Training Resources

In the context of the education and training of CBT practitioners, it is often said that a major barrier is the lack of indigenous and thus culturally appropriate training resources. It is known that assessment theories and evidence-based techniques underpinning the practice of clinical psychology and, from that, CBT in Asia, are largely, if not solely, based on Western research and ideas. The application of Western psychological knowledge in Asia has long been criticised, with many in this field arguing that measurement instruments, techniques, and theories created and validated in the West fail to
address pressing problems relevant to Asian population and cultures (Orchowski et al., 2010; Swannell et al., 2014). As a result, psychotherapeutic techniques based in the West are often judged to be inappropriate and ineffective (Laible et al., 2000).

Similarly, there appears to be uncritical reliance on assessment tools in most Asian countries, without basic research to assess their validity and usefulness in non-Western settings (Laible et al., 2000). Such uncritical importing of Western assessment techniques and theories is thought to have led to frustrated mental health workers, dissatisfied students, and underdeveloped training systems and, from that, to impediments in the development of clinical psychology in this part of the world. To combat this limitation, many psychologists across Asia are advocating for the indigenisation of psychology within their respective countries. A movement towards more indigenous psychology would be likely to result in socially relevant change, better standards of practice, and improved public perception of this profession.

Culture is a broad term that describes a set of attitudes, values, beliefs, and behaviours shared by a group of individuals (Teyber & McClure, 2011). With regard to mental health and illness, cultural characteristics play an important and pervasive role in the development and course of psychological disorders, the outward expression of disorders, and different avenues of coping and seeking help for disorders (Neufeldt et al., 1996; Phang & Oei, 2013). As such, cultural context and values need to be considered when treating mental illness. Few Asian countries, however, have developed indigenised theories of psychological disorders from which to understand and treat those problems. Japan and India may be exceptions to this. Japan has two indigenous therapies, including Naikan therapy and Morita therapy that were developed in the early 1900's based on Buddhist principles (Bernard & Goodyear, 2004). Both are used to treat anxiety and are centred on self-observation and acceptance of uncomfortable emotions. India has therapeutic approaches based on the concepts of Hinduism (Orchowski et al., 2010). However, these indigenous therapies have been criticised because of their religious basis, as opposed to being based on a scientific framework, and because little research has been done to validate their usefulness in reducing psychological distress (Swannell et al., 2014). Indeed, more indigenous therapies are needed, but it is also vital to assess whether these therapies are effective in improving psychological disorders.

Although there certainly are benefits from using indigenous therapies, adaptation of Western theories and therapies may also benefit Asian cultures. Unfortunately, there is little empirical research with Asian populations to verify the usefulness of Western therapeutic practices (Grant et al., 2003). For example, legal gambling is now widespread in Asian countries, yet there has been minimal empirical research in Asia on prevention and treatment of problem gambling (Loo et al., 2008; Raylu et al., 2013).

The cultural context is important in the treatment of psychological disorders and it needs to be considered for effective clinical practice, but clinicians and researchers should also be cautioned to not overinflate the role of this factor in therapy. Given that CBT is a product of Western psychological therapy, there is a push in the literature to modify CBT to bring it more into alignment with Asian cultures. However, such modification of CBT may have unin-
tended consequences. Too much emphasis on the importance of culture in treatment planning can result in less focus on individual clients and their personal values, beliefs, and behaviours that are important in the maintenance of their problems. Thus, assumptions based on the importance of clients' cultural background may rupture the therapeutic alliance and steer treatment planning in a direction that may not benefit the clients. This may be especially true for the second generation of Asians who were born in Western countries (e.g., North America, Australia, and Europe) or, alternatively, those who have migrated to the West and have adapted into Western customs well. Specifically, they may not adhere to Asian cultural norms and may respond better to Westernised therapeutic approaches.

Another reason for caution is that the mechanisms by which culture influences change in treatment are not clearly tied to established theories of psychopathology, such as cognitive or pharmacological theories of depression or anxiety. Thus, it is still unclear how these mechanisms play a direct role in the development and maintenance of psychological disorders. However, it has been suggested that some cultural factors may increase vulnerability to mental illness and influence the expression of a disorder. For example, it has been postulated that it is important to consider traditional Asian values of collectivism in CBT treatment (Hodges & Oei, 2007), and yet the evidence demonstrating that collectivism is linked to common psychological disorders, such as depression (Beck & Dozios, 2011) or anxiety (Clark & Beck, 2010), is weak. It is clear that the beneficial or positive impact of cultural factors has been shown to be important in the understanding and treatment of mental health problems, yet negative, unintended consequences have received little research examination. Overall, there needs to be a balance in treatment, in which cultural factors are considered in formulation of the presenting problem, but the broad therapeutic process is driven by the individual's unique needs. As such, further training in the therapeutic process, including assessment, formulation, and treatment, may have an immediate impact in developing the area of clinical psychology, and from that CBT, in Asia.

It must be noted that training program issues are complex and can intertwine with sociocultural, legal, and political factors. Training programs in clinical psychology in many Asian countries, such as China, India, and Indonesia, were rooted in a medical discipline (Low et al., 2012). In China, psychotherapy is still viewed as a medical practice (R. T. Liu et al., 2014), and thus only those with a medical degree can legally practice psychotherapy, including diagnosis and psychotherapeutic treatment of psychological disorders (R. T. Liu et al., 2014). However, since the review of the mental health act in China in 2014, there may now be some movement away from the rigid view that only those with a medical degree can legally practice psychotherapy.

**Reflecting on Progress**

Over the last three decades, CBT practices in Asia have made significant progress in the following areas:

- Established more solid networking structures (Asian CBT Conference and ACBTA) to encourage Asian CBT practitioners to interact and collaborate with Western researchers and clinicians in an attempt to enhance
learning.

- More solid research papers were presented at the Asian CBT Conferences in the areas of assessment, psychopathological theories, and treatment outcome research. Asian CBT practitioners are better organized to advance CBT research and training. The training programs in Asia are more unified within each country and across countries. The opportunity and availability of training programs have increased, and the quality has also improved.

- More professionally trained CBT practitioners are now practicing in many Asia countries, in particular in Singapore, Hong Kong, South Korea, and Japan. Although there has been significant progress in these areas, it is also clear that more improvement can be made. The following presents some areas that could benefit from further progress:

- Research in the area of the processes of change (i.e., the mechanisms of change), rather than focusing solely on treatment outcome, using effectiveness and benchmarking methodologies would be very important in the future (Boschen & Oei, 2008; Oei, 2015a; Oei & Boschen, 2009; Oei & McAlinden, 2014; Oei et al., 2014).

- The identification of indigenous knowledge in terms of assessment instruments, theories of psychopathology and therapy, and training resources should get urgent priority, and such knowledge should be made available to Asian CBT practitioners.

- Access and equity issues have to be addressed. It is generally known that, in the West, the benefits of CBT are not available to people with lower social-economic status, or to people living in rural areas (e.g., Harvey & Gumport, 2015). The same issues of access and equity are now facing Asian CBT researchers and practitioners (Oei, 2015a, 2015b). Thus, access and equity issues need to receive much more attention in the future.

- Although the effectiveness of CBT treatment is an important issue, in the long run it is cost effectiveness that is more important. Research on the cost effectiveness of CBT treatments is still limited in the West (Tucker & Oei, 2007), and Asian CBT researchers and practitioners need to pay more attention to this important issue in the future.

Many Asian countries have achieved economic success, and some have become economic powers in the world. Economic success comes with a price tag of reduction in the quality of mental health. In the future, mental health issues will become more important in many Asian countries. CBT has been shown to be a very effective and useful technology in the West. There is now emergent evidence showing that CBT can be useful in Asia. It is our hope that Asian CBT will develop further, so that it can be used to benefit Asian clients. The journey will be long, but Asian CBT professionals have made significant inroads. Further progress is needed before this journey can be completed. Asian CBT practitioners and researchers have started out well, and we will end up well.

Author note and Acknowledgements

Dr. Oei is now an Emeritus Professor of Clinical Psychology at the University of Queensland and the Director of the CBT Unit at Toowong Private Hospital, Brisbane. He was a founding member and the first elected president of the Asian Cognitive Behavioral Therapy Association (ACBTA). He is also a visiting Professor at James Cook University Singapore, and at Bei-
jing Normal University and Nanjing University in China. Dr. Oei expressed his sincere thanks and gratitude to his many colleagues and collaborators for making this journey of CBT meaningful and enjoyable.

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