

The Views of Mental Health Professionals Towards Psychotherapy— A Singapore Survey

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Abstract

Objective: There is no published data on how mental health professionals (MHPs) in developing Asian countries view psychotherapy. Since practitioners of psychotherapy may come from both medical and non-medical (e.g. clinical psychology, social work, counselling) backgrounds, differences between the 2 groups may have practical significance. The aims of this study were to examine the views of MHPs in Singapore towards psychotherapy and to determine if there are differences in the views of psychiatric versus non-psychiatric professionals. **Materials and Methods:** Fourteen statements covering various aspects of psychotherapy were given to a sizeable sample of MHPs consisting 70 psychiatric and 70 non-psychiatric professionals. Their responses on a 5-point Likert scale were analysed using appropriate statistical tests to determine similarities and differences of the 2 groups. **Results:** Despite essential agreement in the definition of psychotherapy, significant differences exist between the 2 groups in the following areas: (1) distinction between psychotherapy and counselling, (2) use of medication during psychotherapy, (3) whether the duration of psychotherapy should be determined at the start of treatment, and (4) whether negative effects of psychotherapy exist. There was consensus that psychotherapy should be stopped when psychotic symptoms emerge in the course of such treatment. **Conclusions:** Significant similarities and differences exist in the views of psychiatrists and the other MHPs. The practical implications of these findings for psychotherapy training and the provision of psychotherapy services in Asia are discussed. Literature is reviewed to address the issues raised.

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Introduction

There is a trend in Asia towards a greater application of psychotherapeutic approaches in multidisciplinary settings to emotional and behavioural disturbances. The inaugural issue of *Asian Psychologist* announced landmarks in the education and training of clinical psychology in two major Asian communities. The Graduate School of Medical Studies of the National University of Singapore started a graduate diploma in psychotherapy last year. In Singapore, there has been a rising call for psychotherapeutic approaches to problems such as drug abuse and dependence and domestic violence despite harsh penalties for offenders. Patients are increasingly seeking counselling or psychotherapy for various psychiatric disorders such as mood disorders, anxiety disorders, eating disorders, sexual dysfunctions and personality difficulties. However, not much is known about the views of Asian mental health professionals (MHPs) towards psychotherapy, in particular whether psychiatrists (i.e. those medically trained) have differing views from the other MHPs. This paper highlights significant findings of a major survey conducted in Singapore

that examines the views of a sizeable number of psychiatric (PSY) and other (OTH) MHPs.

Materials and Methods

Participants

Participants were drawn from MHPs in diverse settings in Singapore, including private practice, voluntary welfare organisations (e.g. counselling centres, family services centres, etc), the police and military organisations, and institutional psychiatric units. Expatriate MHPs practising in Singapore were excluded from the study in order to examine local views. A total sample of 122 persons, comprising 59 psychiatric MHPs (PSY) and 63 non-psychiatric MHPs (OTH), completed the survey forms. The sample consisted 91.8% Chinese, the remainder being Malays and Indians. The non-psychiatric MHPs consisted of social workers, counsellors and psychologists.

Procedure

Since English is the *de facto* common language among Singaporeans, the survey was conducted in English. Fourteen

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statements covering various aspects of psychotherapy were given. A 5-point Likert scale was used to make standardised comparison possible and to permit a quick completion by the participant. Respondents have the option to remain anonymous and personal identifying information like age and sex were not required. Minimal information about the setting of practice (whether psychiatric or non-psychiatric), years of practical experience, and psychotherapy training received were asked. The forms, together with stamped addressed envelopes to the author, were personally handed out to 140 persons with a brief explanation about the intent of the survey. These measures were employed to ensure true responses from a sufficiently representative sample. The respective response rates were 84.3% (59/70) for PSY and 90% (63/70) for OTH.

Statistical Analysis

The results were analysed using SPSS for Windows on an IBM compatible computer. Appropriate statistical tests were employed to examine for statistical significance. The *t*-test was used unless the Levene's test for equality of variances suggested that it was inappropriate. In those cases, the Mann-Whitney U-test was used.

Results

(A) Characteristics of Psychiatric (PSY) versus Non-psychiatric (OTH) MHPs Surveyed

The psychiatric MHP group has more years of experience compared with the non-psychiatric MHP group. Three out of 5 of OTH had 5 or less years of experience; whereas 3 out of 5 of PSY had more than 5 years of experience. The proportions with formal psychotherapy training in the 2 groups are comparable, although the duration of formal psychotherapy training appears to be longer for the non-psychiatric group. There are differences in the theoretical orientation of psychotherapy training undergone by

psychiatric and non-psychiatric MHPs (Table I).

(B) Definition of Psychotherapy

There was general acceptance by both groups of the given definition of psychotherapy as "a form of treatment based on the systematic use of a relationship between therapist and patient to produce change in cognition, feelings and behaviour". 96.6% of PSY and 89.9% of OTH agreed with the given definition.

(C) The Distinction of Psychotherapy from Counselling and Other Supportive Type of Clinical Encounter

A statistical significant difference was found between the views of PSY versus that of OTH MHPs regarding the unique status of psychotherapy ($P = 0.001$ using *t*-test). Seventy-eight per cent of psychiatrists saw psychotherapy as different from counselling. 52.4% of non-psychiatric MHPs agreed that psychotherapy should be differentiated from counselling or other type of clinical encounter. Further analysis suggested that this difference was likely to be more marked between psychiatrists versus social workers. Although there was no statistical significant difference detected between those with or without formal psychotherapy training, comparing the views of those with no formal psychotherapy training versus those with psychodynamic psychotherapy training revealed a significant difference ($P = 0.013$, $n = 84$, using Mann-Whitney U-test). In summary, psychiatrists (particularly those with psychodynamic psychotherapy training) are more likely to view psychotherapy as distinct from counselling. Non-psychiatric MHPs (particularly social workers) are likely to disagree with this view.

(D) Use of Psychotropic Medication During Psychotherapy

33.4% of non-psychiatric MHPs agreed that psychotropic

TABLE I: CHARACTERISTICS OF PSYCHIATRIC VS. NON-PSYCHIATRIC MENTAL HEALTH PROFESSIONALS

Mental health professionals	Psychiatric (PSY)	Non-psychiatric (OTH)	Remarks
No.	$n_1 = 59$	$n_2 = 63$	
Years of experience	$x_1 = 2.254$ years $sd_1 = 1.321$ years	$x_2 = 1.793$ years $sd_2 = 1.166$ years	significant difference ($P = 0.043$ using <i>t</i> -test)
Received formal psychotherapy training	number = 28 $q_1 = 47.5\%$	number = 25 $q_2 = 39.7\%$	no significant difference ($P = 0.387$ using χ^2 test)
Duration of formal psychotherapy training	mean = 1.786 years $sd = 0.995$ years	mean = 2.375 years $sd = 0.824$ years	significant difference ($P = 0.026$ using <i>t</i> -test)
Three most frequent theoretical orientation of psychotherapy training received (frequency)	psychodynamic (14) cognitive-behavioural (6) eclectic (6)	eclectic (9) cognitive-behavioural (7) systemic (5)	70.4% of PSY with formal training were trained in the UK. 88.0% of OTH with formal training were trained in USA & Asia.

medication was best avoided during psychotherapy. 89.9% of psychiatrists disagreed that psychotropic medication should be avoided in patients undergoing psychotherapy. The difference in views between the 2 groups was statistically significant ($P = 0.022$ using t -test). There was no statistical difference however, when comparison was made between those who had received formal psychotherapy training versus those without such training.

(E) Duration of Psychotherapy Determined at the Start

The difference in views between the 2 groups was statistically significant ($P = 0.001$ using t -test). 55.5% of non-psychiatric MHPs agreed that the duration for a course of psychotherapy should be pre-determined at the start. 53.6% of psychiatrists disagreed that the duration for psychotherapy should be determined at the start. Those MHPs with formal psychotherapy training in Cognitive-Behavioural Therapy are more likely to prefer a predetermined duration, although no statistical significance was detected when comparison was made between those who had versus those who had not received formal psychotherapy training on the whole.

(F) The Existence of Negative Effects in Psychotherapy

With regards to negative effects in psychotherapy, statistical significant difference existed between the views of psychiatrists and those of non-psychiatric MHPs ($P = 0.016$ using t -test) with psychiatrists more strongly believing that psychotherapy did have negative effects. Approximately $\frac{4}{5}$ of psychiatrists agreed that negative effects exist; while less than $\frac{1}{2}$ of non-psychiatric MHPs agreed with this view. Although formal psychotherapy training did not appear to result in significant difference of view in this aspect, systemic psychotherapists were more likely to believe that negative effects exist.

(G) Conditions Under Which Psychotherapy Should Be Stopped

There was no statistical significant difference detected in the views of psychiatrists and non-psychiatric MHPs as to whether psychotherapy should be stopped when there was increased frequency of self-harm behaviour or suicide attempts, worsening of existing symptoms, emergence of psychotic symptoms or continuing drug or alcohol abuse. The majority of MHPs agreed that psychotherapy should be stopped if psychotic symptoms emerged. Most felt that psychotherapy need not be stopped when there was increased self-harm behaviour, worsening of symptoms, and ongoing drug and alcohol abuse.

(H) Cost-effectiveness of Psychotherapy

There was no statistical significant difference in the views of psychiatric and non-psychiatric MHPs with

regards to the cost-effectiveness of psychotherapy. 56.5% of all MHPs viewed psychotherapy as cost-effective, whereas 22.2% held the opposite view. No statistical significant difference was detected between the views of those who had received formal psychotherapy training versus those without.

(I) Modification of Technique for Asian Patients and Use of Reassurance

There was no statistical significant difference between the 2 groups of MHPs in this regard. Majority of MHPs (57.4%) agreed that technique modification was necessary for non-English speaking patients. Reassurance was viewed as an acceptable technique in psychotherapy regardless of the cultural background of the patient, including Asian patients.

Discussion

Despite essential agreement in the views of psychiatrists, social workers, psychologists and counsellors with respect to (a) the definition of psychotherapy as “a form of treatment based on the systematic use of a relationship between therapist and patient to produce change in cognition, feelings and behaviour”,¹ (b) its cost-effectiveness, and (c) applicability in the Asian community; significant differences were detected as well between the psychiatric and non-psychiatric MHPs.

In this survey, psychiatrists regard psychotherapy as distinct from counselling, favour the inclusion of psychotropic medication during psychotherapy, do not expect the duration of psychotherapy to be predetermined at the start, and believe that negative effects of psychotherapy exist as compared to other MHPs. These differences may be explained by the fact that psychiatrists are medically qualified to prescribe psychotropic medication, and on a whole work with patients with more severe emotional disturbances than other MHPs. As such, psychotherapy is regarded as a more specialised form of intervention for clinical populations that may be long-term and that might have detrimental effects if improperly carried out.^{2,3}

In the training of psychotherapy for both psychiatrists and other MHPs, these areas of differences will need to be addressed to achieve consensus. Findings from current research should be applied to these areas. Of practical significance are the following issues:

- 1) the use of psychotropic medication in psychotherapy,
- 2) the use of time-limited versus longer term psychotherapy, and
- 3) the management of possible negative effects of psychotherapy.

Current literature supports the benefits of combining psychotropic medication and psychotherapy in the treatment of acute and chronic depression;^{4,5} various anxiety disorders;⁶ certain types of eating disorders;⁷ addictions;⁸⁻¹⁰ and certain conditions associated with personality disorders.¹¹⁻¹³

There is a growing trend towards brief or time-limited psychotherapy in recent times. This is partly driven by the economics of health care delivery in an age of rising costs that has resulted in a view that innovative short-term psychotherapy is more effective than long-term psychotherapy and that has also raised questions about the acceptability of long-term psychotherapy. This trend is further encouraged by evidence for the efficacy of modifications of the psychodynamic technique in the context of short-term treatment, i.e. brief or time-limited psychodynamic psychotherapy.¹⁴

Various writers have compared brief versus long-term psychotherapy and have accepted that there is still a role for long-term psychotherapy.^{15,16} Current literature supports the view that long-term psychotherapy is indicated for a group of psychiatric patients with psychosomatic problems,^{17,18} certain types of personality disorders,^{19,20} chronic depression,²¹ alcohol or substance abuse and dependence,²² eating disorders²³ and schizophrenia.²⁴ There are usually technical modifications in such instances including the incorporation of supportive measures.

Despite the controversy and difficulty of studying negative effects in psychotherapy, there is both evidence and consensus among expert psychotherapists that they occur.²⁵⁻²⁷ Outcome studies have shown the presence of 10% negative effect sizes which provide added evidence for negative therapeutic effects.^{28,29} Factors to do with patient characteristics, therapist personality and competence, and technique interaction effects contribute to negative effects in psychotherapy. Sachs³⁰ conducted one of the best studies examining the process that leads to negative effects.

In the provision of psychotherapy services, the initial assessment of patients should preferably involve discussion between a psychiatrist and a non-psychiatric MHP. While this is likely to be the case in institutional settings, provisions should be made for non-psychiatric MHPs doing psychotherapy in private or community settings to have consultations with psychiatrists. Differences of views between MHPs should be anticipated but a joint decision regarding the suitability of psychotherapy for a given patient could then be made in the interest of the patient.

The questionnaire used in this survey thus demonstrated value in addressing issues of psychotherapy training and service provision in an Asian setting. However, the validity of its findings for non-psychiatric MHPs needs to be

verified by further research involving a more representative sample to be drawn from this population.

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APPENDIX I

A SURVEY OF ATTITUDES TOWARDS PSYCHOTHERAPY

The purpose of this survey is to find out the attitudes of mental health professionals working in Asia.

Please state your name and qualifications only if you would like to be acknowledged when the results of this survey is published.

Name: _____

Qualifications: _____

Setting of Practice: _____

Please circle the response that corresponds most closely to your view.

There is no right or wrong answer.

	Strongly agree	Agree	Unsure	Disagree	Strongly disagree
1. Psychotherapy is a form of treatment based on the systematic use of a relationship between therapist and patient to produce change in cognition, feelings and behaviour.	1	2	3	4	5
2. Psychotherapy should be differentiated from counselling or other supportive type of clinical encounter.	1	2	3	4	5
3. Psychotropic medication (e.g. antidepressants, sedatives) should be avoided as far as possible in patients undergoing psychotherapy.	1	2	3	4	5
4. The duration for a course of psychotherapy should not be decided at the start of treatment.	1	2	3	4	5
5. Psychotherapy does have negative effects.	1	2	3	4	5
6. Psychotherapy should be stopped if the following occurs:-					
6.1 Increased frequency of self-harm behaviour or suicide attempts.	1	2	3	4	5
6.2 There is worsening of existing symptoms.	1	2	3	4	5
6.3 Psychotic symptoms emerge.	1	2	3	4	5
6.4 There is ongoing history of drug or alcohol abuse.	1	2	3	4	5
7. For patients to improve with psychotherapy, they almost invariably will deteriorate somewhat.	1	2	3	4	5
8. Psychotherapy is not cost-effective.	1	2	3	4	5
9. Different techniques are needed for psychotherapy conducted with non-English speaking patients.	1	2	3	4	5
10. The giving of re-assurance is generally discouraged in psychotherapy.	1	2	3	4	5
11. The giving of re-assurance is appropriate in psychotherapy for Asian patients.	1	2	3	4	5
12. How many years have you been in psychiatric/social work/counselling practice? (Please circle what kind of practice you are in.)	_____years				
13. Have you ever received formal psychotherapy training (supervised psychotherapy with 2 or more patients/clients during a period of more than 6 months)?	Yes	No			
If your answer to (13) is Yes					
14. How long was your training?	_____years				
15. What was the main theoretical orientation of the training?	psychodynamic cognitive/behavioural systemic humanistic/existential others				
16. Where did you receive your training?	Asia North America UK Other parts of Europe Australia/New Zealand Others				