COMPARING CHARACTERISTICS, PRACTICES AND EXPERIENTIAL SKILLS OF MENTAL HEALTH PRACTITIONERS IN NEW ZEALAND AND SINGAPORE: IMPLICATIONS FOR CHINESE CLIENTS AND COGNITIVE BEHAVIOUR THERAPY

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ABSTRACT

This study compared the characteristics, self-reported practices and experiential skills of mental health practitioners (MHPs) in New Zealand and Singapore with the aim of benefiting both nations in managing the mentally ill. A mixed-research design was used consisting of a mail questionnaire survey and a structured interview. For each country, mail questionnaires were sent to 300 MHPs, namely, counsellors, psychiatrists, psychologists, psychotherapists, and social workers, while structured interviews were held with 12 MHPs. Potential participants were drawn from available electronic or printed publications on counselling and psychotherapy services in both countries. Those drawn from individual listings of MHPs were systematically sampled, whereas those drawn from organisational listings of MHPs were sampled by way of estimation.

Despite the relatively low response rates of 20% to 27% from the participants of the mail questionnaire, the major findings were supported and augmented by those from the structured interviews in the combined analysis of results. Results were categorised into personal, professional and practice characteristics of MHPs. Personal characteristics included demographic characteristics. Professional characteristics included training characteristics, primary job affiliation and use of Western therapy models and interventions. Practice characteristics were sub-divided into five categories: practice setting; diagnostic system and assessment procedures; client and caseload; gender/ethnic match; and experiential skills.

Similarities in personal and demographic characteristics between MHPs of both New Zealand and Singapore were found with respect to gender, ethnicity, and language ability. Differences in these characteristics were found with respect to age range and religious affiliation. Similarities in professional characteristics between MHPs of both

countries were found with respect to country of therapy training, qualification in therapy, number of years of supervised training received, and use of Western therapy models and interventions. Differences in these characteristics were found with respect to primary job affiliation, availability of clinical psychology programmes, years of experience in therapy, and registration of practice. Similarities in practice characteristics between MHPs of both countries were found with respect to relevance of therapy models, focus of practice, diagnostic system and use of assessment procedures, clients seen, clients' presenting problems, and gender/ethnic match. Differences in these characteristics were found with respect to preferences of therapy models, and average number of sessions per client. Similarities in experiential skills between MHPs of both countries were found with respect to handling of self-disclosure, religious or spiritual issues, and traditional healers.

Implications for Chinese clients and cognitive behaviour therapy were discussed, as well as limitations of the study.

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TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1

INTRODUCTION

Over fifteen years of personal commitment to applied psychology culminating in a recent phenomenological stint in counselling mentally ill clients in Singapore inspired this research. More promising is the learning that certain features of New Zealand and Singapore provide for comparisons: composition of population, multiculturalism, use of English as the common language, degree of Westernisation, and especially, the growing demand for mental health care and services.

New Zealand

New Zealand, essentially a modern Western state with features of colonialism, independence, and holistic worldview, is becoming more multicultural. Its land expanse of 268,000 square kilometres (The Treasury, 2006) holds a population of 4 million people, comprising 67.6% European ethnic groups, 14.6% Māori, 9.2% Asian ethnic groups, and 6.9% Pacific Island peoples (Statistics New Zealand, 2006). Asians make up the fastest-growing ethnic population in New Zealand today with the removal of barriers to immigration in 1986 (Williams, Graham, & Foo, 2004). Chinese form the largest ethnic group among the Asian population, followed by Indian and Korean. Other Asian ethnic groups include Cambodian, Filipino, Japanese, Malay, Sri Lankan, Thai and Vietnamese (Ho, Au, Bedford, & Cooper, 2003). It is expected that the 23.5% of New Zealand's potential workforce of non-Europeans in 2001 will have increased to around 33% in twenty years (Bryson & Hosken, 2005).

English is New Zealand's first language, with the Māori language as the second. Mainstream New Zealanders are predominantly in the middle-class. The degree of Westernisation and modernisation in New Zealand resembles that of United Kingdom and Australia. Notably, contemporary society of New Zealand as well as its public policy is influenced by the principles of the Treaty of Waitangi of 1840 signed between the Māori people and the British Crown (Bryson & Hosken, 2005). The Treaty of Waitangi was considered the most important event in New Zealand's history among university students and the general public (Liu, Wilson, McClure, & Higgins, 1999). Where psychology is concerned, training programmes of clinical psychology have focussed on being culturally responsive to Maori aspirations and values, reflecting the imperatives of the Treaty of Waitangi (Evans, 2002).

Mental Health Development in New Zealand

Presently, mental health care of New Zealand's population is the concern of 21 District Health Boards and approximately 400 non-governmental organisations in mental health services (New Zealand Health Information Service, 2004). Mental health care are offered through the services of mental health practitioners (MHPs) in private practice and at the public hospitals and institutions, including services of general practitioners, school counsellors, and specialists. A study by Marie, Forsyth, and Miles (2004) testifies to the provision of mental health services by the MHPs. They have found that the New Zealand public perceived the following as useful options for the treatment for depression: confidant, family physician, psychiatrist, clinical psychologist, community support counsellor, anti-depression medication, having a holiday, self-help groups, and psychotherapy.

With regard to policy on mental health practice, the honouring of the Treaty of Waitangi creates an obligation for MHPs to be sensitive to and have at least a basic competence in the bi-cultural aspects of New Zealand society. From the standpoint of psychologists, cultural competence is a mix of attitudes, knowledge and skills to work effectively with people of different cultural backgrounds. The New Zealand Psychological Society states its commitment to biculturalism and cultural diversity. This is reflected in their establishment of the National Standing Committee on Bicultural Issues in the rules of the Society, and in the Code of Ethics for Psychologists working in New Zealand which applies to all members of the Society, the New Zealand College of Clinical Psychologists and all other registered psychologists (Bryson & Hosken, 2005). Notably, the emphasis is primarily bicultural.

Medical management, counselling and psychotherapy, and rehabilitation constitute the various treatment methods for the mentally ill. Mental health services of New Zealand have moved from institution-based to community-based (New Zealand Health Information Service, 2004), and are shifting the input-based strategy to an outcome-based strategy (Kreible, 2003). Traditional psychiatric hospitals no longer exist, and psychiatric units have been integrated into public hospitals and the general health system—a step in destigmatisation of mental illness. Consequently, psychiatric patients have been released into the community (Coney, 1995). Public reaction has not been accommodating. A study by Read and Harre (2000) found that the New Zealand public held unhelpful perceptions of the mentally ill as dangerous, antisocial and unpredictable.

The Ministry of Health of New Zealand, however, is adamant in its mental health programme. In 2004, it unveiled its second National Mental Health and Addiction Plan encompassing and augmenting the 1994 "Looking Forward" and 1997

"Moving Forward" strategies, and the 1998 "Blueprint" (Ministry of Health, 2004). The aims were to decrease prevalence of mental illness and mental health problems, increase health status and reduce impact of mental disorders on consumers, carers and community. Over and above that, clinical practice guidelines were recently established for carers and consumers (Lammersma, 2005). These moves were made in response to the country's growing mental health statistics.

The Mental Health Commission (1998) reported that at any one time about 20% of New Zealand's population have a diagnosable mental illness, of which 3% with disabling mental illness required treatment from specialist mental health services, and 17% with less severe, moderate and milder illness that did not need treatment. In 2002, 87,576 mental health clients were seen by the District Health Boards—of these, 78.2% were "Others" (a mislabelled category which consisted mainly of Caucasians), 16.9% were Māori, 3% were Pacific Island peoples, and 1.9% were Asians (New Zealand Health Information Service, 2005). In 2003, 88,000 New Zealanders or 2% of the population have used specialist mental health services (Ministry of Health, 2004). As with developed countries, New Zealand also faces a 2-3% population with mental illness. Adding to the list of mentally ill are the immigrants. The challenges faced by the influx of migrants to New Zealand included poor English language skills, finding employment, changes in familial roles and social support systems, or trauma experienced prior to immigration. It has been reported that one in five migrants experienced some form of discrimination in New Zealand (Williams, Graham, & Foo, 2004).

Reportedly among New Zealand clients, Māori and Pacific Island clients were over-represented in psychiatric wards (Johnstone & Read, 2000; Love, 1999; Tofi, 1996) whereas Asian clients were under-represented (Abbott, Wong, Williams, Au, &

Young, 2000; Ngai, Latimer, & Cheung, 2000). Perhaps, the difference in incidences among these clients lies in the attitudes and behaviours of the people. For example, Indians between the ages 18 and 25 in New Zealand were found to have maintained an integrated or bicultural ethnic identity (Raza, 1997). Integration or biculturalism occurs when an individual becomes proficient in the culture of the dominant group while retaining proficiency in the indigenous culture (Kim & Omizo, 2005). In other words, these individuals behave according to the culture of the people they are with. Because of using this "cultural frame switching" in their socialisation process, bicultural individuals have apparently fewer or no mental health problems (Hong, Morris, Chiu, & Benet-Martinez, 2000).

Over-representation of Māori and Pacific Island clients in mental health care could be due to a lack of understanding of their causal attributions to mental health and treatment requirements by the health authority (Johnstone, 1997; McLeod, 1999; Stewart, 1995; Taufa, 1996; Tofi, 1996). Whereas among Asians in New Zealand, help-seeking behaviours and socio-cultural influences were the main factors for their unwillingness to seek medical help or delayed entry into the mental health system when ill (Ho, Au, Bedford, & Cooper, 2003; Ngai, Latimer, & Cheung, 2000). Help-seeking behaviours would include self-help (as in staying at home, taking tonic drinks, purging medicine, vitamins or minerals, or going on special diets; notably, food therapy is tied to folk medicine among Chinese people; Anderson & Anderson, 1978) or relying on family members, close relatives and friends to resolve problems. Social cultural influences included social stigma of mental illness and lacking the ability to communicate in English. The Western practice of seeking help from a stranger such as a therapist may be culturally inappropriate from an Asian collectivistic perspective since the behaviours, emotions, thoughts, and motivations of interdependent selves are seen as

closely embedded with important others (Yeh, Inman, Kim, & Okubo, 2006). Perhaps, under-representation of Chinese clients in mental health services could be also due in part to cultural mistrust, a contributing factor that has been found with African American (Whaley, 2001).

Aside from Western medicine, traditional healing practices (e.g., the use of herbal medicine and consultation with traditional healers) are sought after by culturally diverse New Zealanders, and are gaining awareness among its MHPs (Ritchie & Ritchie, 1999). Limited studies, however, are available on the use of traditional health practices by Asian migrants (Ho, Au, Bedford, & Cooper, 2003). Most New Zealanders, however, would first consult a general practitioner of Western medicine for treatment of illness (Culbertson, 2001). There is a growing need for health services in New Zealand to respond to the mental health needs of the Māori (Cherrington, 1994; Johnstone & Read, 2000; Paewai, 1997), Pacific Island peoples (Tofi, 1996) and the Asian population (Tse, Bhui, Thapliyal, Choy, & Bray, 2005). Nonetheless, with the availability of information on wellbeing and changing healthcare policies, New Zealand is moving towards a better quality of life and healthcare for its people (Krieble, 2003; Lurie, 2005).

Singapore

Singapore, essentially an Asian state with features of collectivism, interdependence, familism, hierarchy and holistic worldview, is a complex metropolis embracing a mix of Eastern and Westernised values, attitudes and lifestyles. Its land area of 699.4 square kilometres (Statistics Singapore, 2006) also holds a population of 4.48 million people comprising 76.8% Chinese, 13.9% Malays, 7.9% Indians and 1.4%

other ethnic groups (Statistics Singapore, 2006). English was made the working language since 1981 (Gupta, 1994). Mainstream Singaporeans are attaining middle-class status whose concerns are career, education, materialism, progress, and social mobility (Soong, 1997). The degree of Westernisation in Singaporeans, however, lies on a continuum depending on personal or group preferences, and environmental influences. A study by Ward (1999) found that Chinese in Singapore preferred integration or biculturalism in their adaptation to multiculturalism.

Mental Health Development in Singapore

Mental health care of Singapore's population is the concern of two public psychiatric hospitals (Statistics Singapore, 2006), and numerous private organisations in mental health service (exact numbers are not available), though general practitioners and school counsellors form the first line of consultation to the mentally ill. More and more public hospitals are being restructured (made quasi-government) with the government's move to make the people health conscious and responsible for their own health. Clients with mental illness, however, can visit the hospitals directly for consultation. Mental health care at the various hospitals generally includes medical treatment, counselling and psychotherapy, and rehabilitation. Mental health services are moving away from institution-based to community-based.

In 2001, the Singapore government launched a 10-year preventive programme, "Mind your Mind", enlisting the assistance of MHPs to reach out to the public on topics of stress management, destigmatisation, and common mental disorders (see Yeo, 2004, for an account of mental health programmes in Singapore). Additionally, family service centres with integrated counselling services were established within public housing

estates (Sim, 1999), in which over 90% of Singaporeans reside (Statistics Singapore, 2006), to provide better access to mental healthcare.

As with other developed countries, depression, anxiety disorder and schizophrenia, at prevalence rates of 7.3%, 9.3% and 0.75% respectively, are identified as the major mental disorders in Singapore (Yeo, 2004). As with people of other developed countries, Singaporeans have high needs for mental healthcare but few consult with MHPs. A study by Ng, Fones, and Kua (2003), based on data from the 1996 Singapore National Mental Health Survey, found that 37% of the general population indicated they would seek professional help if they experienced a serious emotional or mental problem; 2.6% of the population had used the services of an MHP, and that only 5.9% of persons with psychiatric disturbance sought professional help. Psychotic illness, however, gets a little more attention with Singaporeans. For example, Kua (2004) reported that 80% of patients with first-episode schizophrenia were referred to the National University Hospital within 6 months of the onset of illness. Yeo (2004) reported that 24% of patients with first episode psychosis sought help from traditional healers at the first onset of symptoms. Generally, Singaporean clients still hold high levels of trust and confidence towards traditional healers, and found them instructive, interactive, directive, with an element of spirituality (Samion, 1999).

As mentioned, traditional healing practices (e.g., use of herbal medicine and consultation with traditional healers) coexist with Western medicine in Singapore (Lee, 2002; Lim & Bishop, 2000). Most Singaporeans, though, would first consult a doctor of Western medicine for treatment of illness (Ng, Fones, & Kua, 2003) due to the ubiquity of Western medicine that has predisposed their health beliefs, and relegated traditional healing practices to second choice (Lim & Bishop, 2000). Western medicine is perceived as appropriate for treating diseases when symptoms are acute, and are often

given out in standardised doses. On the other hand, herbal medicine (like Chinese medicine), considered when Western medicine is not helping, is suitable for problems low in psychological or spiritual causes, individually customised, and includes a recommendation of diet to go with the problem (Cobiac, 1998; Lim & Bishop, 2000).

There is a growing demand for adolescent mental health services (Lee, Fung, Teo, Chan, & Cai, 2003), and the need for more general therapy services, both in training and in clinical settings (Elliot, 1999). Elliot (1999) found that there were more psychiatrists than clinical psychologists in Singapore, and Kua (2004) reported that it was possible in a psychiatric clinic to see between 10 and 20 patients in 3 hours. MHPs generally considered Western therapy practices still developing in Singapore, and found them more acceptable with English-educated Singaporeans (Lee & Bishop, 2001). However, the personal meanings of Singaporeans may be different as their adopted English is a combination English and language of the ethnic group (e.g., Mandarin) (Elliot, 1999; Wong, Ishiyama, & Wong, 1999). What is needed in Singapore now is to establish a registration body to ensure ethical delivery of service (Chong & Ow, 2003), to review their status and practicality, and to carry out more published research which is lacking compared with that of Hong Kong or Taiwan (Sim, 1999). Nonetheless, with acquired affluence and the availability of information on wellbeing, Singaporeans too are going after better quality of life and healthcare (Ow, 1998; Tseng, Ebata, Kim, Krahl, Kua, Lu, et al., 2001).

Summary

Taken together, New Zealand and Singapore share many similarities in the multicultural diversity of population, use of English as the common language, degree of modernisation and Westernisation, and especially the growing demand for mental health

care and services that are managed both by counselling and psychotherapy and by traditional healing practices. Thus, this study aims to compare the characteristics, practices and experiential skills of New Zealand and Singapore MHPs in the hope of discovering benefits for each other in the provision of counselling and psychotherapy services. First, a review of Western counselling and psychotherapy is carried out.

CHAPTER 2

WESTERN THERAPY

This chapter begins with a brief review of existing literature on Western psychological therapy in general, highlighting the development of cross-cultural therapy, and then examines their influence on the training and mental health practices in New Zealand and Singapore. Four factors of interest that influence the therapist-client relationship in these two countries form the focus of discussion: gender and ethnicity of therapist and client; therapist self-disclosure, handling of religious or spiritual issues, and attitudes towards use of traditional healing practices by clients. This chapter ends with a review of comparative research and studies carried out on characteristics, practices and experiences of MHPs in various countries.

Definitions

Western Therapy

What precisely distinguishes counselling from psychotherapy has remained unresolved. For instance, some researchers have argued that in psychotherapy, therapists are thoroughly trained, the focus is more deeply on uncovering the unconscious, and it is more of a medical term relating to psychiatrists, whereas counselling relates more to the non-medical settings. From a different perspective, both counselling and psychotherapy employ the same theoretical methods but are diverse in knowledge and activities (Nelson-Jones, 2006). Although counselling and psychotherapy differ in meanings perceivably, more similarities prevail over differences

where offering of professional services is the concern. It would be fair but laborious to refer to counselling and psychotherapy constantly, and simply referring to therapy alone could be confusing. Hence, the preferred words for use in this thesis from here on are Western therapy.

Traditional Healing Practices

Traditional healing practices have been used by people worldwide for a long time, which include use of acupuncture, fortune telling, herbal medicine, meditation, praying, religious counselling, traditional healers, yoga, and many more. They have been variously referred to as indigenous therapies, traditional therapies or traditional healing systems. In the recent discussion document of New Zealand (Ministry of Health, 2003), traditional healing practices were subsumed under the definition of complementary and alternative medicine. For use in this thesis, however, traditional healing practices are the preferred words to distinguish them from Western therapy.

Western Therapy

Early history of Western therapy was dominated by the development of different schools of psychology (Woolfe, Dryden, & Strawbridge, 2003). Reinecke and Davidson (2002) have provided an account of the various orientations of psychological models and treatment interventions used in Western therapy. In a nutshell, they included individual psychology, object relations, self-psychology, supportive-expressive psychodynamic therapy, behavioural therapy, rational-emotive behaviour therapy cognitive therapies, schema-focused therapy, interpersonal psychotherapy, couple and family therapy, integrative psychotherapy, and psychopharmacology. Subsequently,

each of the psychological models and treatment interventions was distinctively defined. Individual psychology suggested that people functioned as an indivisible whole and as part of a larger community. The relational model of psychoanalysis focussed on the relationship of the self to mental representations of objects, and the re-enactment of this inner world in interpersonal relationships and fantasies about relationships. Self-psychology proposed that a primary aim of development was maintaining a sense of a cohesive and authentic self. Supportive-expressive psychodynamic therapy suggested that individuals re-enact core conflictual relationship themes. Behavioural therapy used the principle of reinforcement or reinforcers to treat problems. Rational-emotive behaviour therapy postulated that human problems stemmed from distortions in thinking which led to the development of a self-critical, judgmental cognitive set. Cognitive therapy posited that human problems stemmed from the interaction of learned cognitive vulnerabilities (e.g., cognitive distortions, maladaptive beliefs, sociotropic personality style) and personally-relevant stressful life events. Schema-focused therapy proposed that human problems stemmed from the activation of latent maladaptive early schema or tacit beliefs. Interpersonal psychotherapy proposed that problems resulted from difficulties in social relationships, and exacerbated these difficulties through a cycle of interpersonal friction and withdrawal. Group therapy, such as couple and family therapies, focussed on intrapsychic, developmental, and interpersonal dynamics. Integrative psychotherapy, encompassing several schools of thought, proposed that human problems were multiply determined, and that individuals might vary according to underlying factors that maintained their distress. In psychopharmacology, biological and environmental factors interacted to produce specific symptoms in humans with problems.

Young (1993) asserted that there were between 100 and 250 systems of counselling and psychotherapy while Cunningham (1999) estimated the presence of over 450 different approaches to psychotherapy before the turn of the millennium. Nevertheless, the use of Western therapy has spread from the Europe and America to other parts of the world, including New Zealand and Singapore (Nelson-Jones, 2006). The World Health Organisation sees Western therapy as playing diverse roles in the provision of basic health care. These include the identification of mental disorders, education in common mental health problems, identifying at-risk individuals or groups, mobilising support groups, running elementary programmes, diagnosing and treating, consulting, and networking with other healthcare sectors to promote and raise awareness of mental health issues (Sartorius, Ustun, Silva, Goldberg, Lecrubier, Ormel, 1993).

With the ubiquitous use of Western therapy, two distinct camps emerged to assert their views. From the Universalist's view, the Western world has advocated that their well-researched and empirically supported therapy models are universally applicable for assessment and treatment of mental health problems (Chambliss, 2000; Maxie, Arnold, & Stephenson, 2006), perhaps, similar to the efficacy of Western medicine. Studies from the non-Western world have lent support to this advocacy (e.g., Kong, 2005; Raj, Kumaraiah, & Bhide, 2001; Wan Mahmud, Awang, Herman, & Mohamed, 2004). From the Contextualist's view, the Eastern and Southern worlds have argued that Western therapy is not appropriate for assessment and treatment of peoples of non-Western cultures (e.g., Dwairy, 1999; Naidoo, Olowu, Gilbert, & Akotia, 1999; Padilla, 1999; Poortinga, 1995; Sue & Sue, 1999). Western therapy has been criticised as cultural-bound to the EuroAmerican-centered perspective reflecting the customs, language, philosophies and values of those cultures. For example, a study by Johnstone (1997) highlighted the inappropriate use of European diagnostic systems on Māori

patients in New Zealand. Cultural bias is even found among Western-trained therapists (Lambert, 2004). Nevertheless, multicultural therapists have counter-proposed localised or indigenous psychological and therapy models (e.g., Kim, 2000; Love, 1999; Naidoo et al., 1999; Raney & Çinarbas, 2005; Yang, 2000).

The crux of these contentions is about cultural differences—that psychological theories and techniques developed in the West cannot account for and assist behaviours of cultures other than those of Europe and North America. This deficiency becomes more apparent as more and more countries become multicultural through transmigration. Hence, and of late, a third camp emerged, the Integrationist's view, calling for the integration of Western therapy models with indigenous ones to make psychology and therapy universal (e.g., Li, Duan, Ding, Yue, & Beitman, 1994; Shams, 2002; Yang, 2000). An appealing example of the Integrationist's view came from Lee (2002) who cited personal clinical experiences of combining cognitive behaviour therapy (CBT) with Chinese folk beliefs and practices to resolve clients' problems. Further support to the Integrationist's view came from Walsh (1995) who argued that Western psychologists might have underestimated some Asian therapies in which experimental studies have demonstrated their abilities to induce psychological, physiological and psychotherapeutic effects.

Cross-cultural Psychology and Therapy

Deriving from Western therapy and consisting a mix of the above therapy views, is multicultural or cross-cultural therapy. Noteworthy is that multiculturalism has been defined as the fourth force in psychology, complementing the psychodynamic, behavioural and humanistic explanations of human behaviour (Locke, 1992), and many countries are becoming more multicultural with transmigration. Over two decades ago,

literature on cross-cultural psychology focussed on the scope and theoretical models for multicultural therapy, cross-cultural perception of therapists, and suggestions for training and practice of therapy in the cross-cultural environments (Allwood, 2002). Recent literature on cross-cultural therapy emphasised various aspects of culturally sensitive practices such as accepting the client's upbringing and ethnicity, life experiences and purposes, perceptions of the world, definition of health, learning styles, and among other things, the acceptance of the role of ritual in their lives and their different expectations of the therapist or healer (Al-Krenawi, 1999; Poortinga, 1999; Locke, 1992).

Furthermore, many researchers have made proposals for the accomplishment of cross-cultural therapy. For example, a holistic and synergetic culture-specific model was proposed by Jespersen and Herring (1993) for providing appropriate guidance and counselling services to Māori youths in New Zealand. Specific strategies were suggested by Wedding (1995) for conducting therapies with different ethnocultural groups: using action-oriented and directive approaches for African-American clients, reframing psychological problems as mental disorders with Latinos, using highly structured therapy with Asian-Americans, and adopting an authoritative role with Filipino Americans. African-British therapists were observed to have begun to develop their own model of cross-cultural counselling (Banks, 1999). A template was proposed by Longhi (2000) for incorporating cultural-sensitive clinical practices in the treatment of substance abuse and dependence for Native Americans. A cross-cultural counselling approach that comprised a mutually cultural adjustment process was advocated by Yan and Lam (2000). A number of conditions was recommended by Vicary and Andrews (2000) to work with indigenous Australians. Given the lack of clear theoretical models for multicultural therapy and specific factors to explain treatment effectiveness, Kim,

Ng, and Ahn (2005) proposed four common factors that might serve as useful bases for effective therapy with diverse clients: client's expectation for therapy success; a shared worldview between therapist and client; the therapeutic relationship; and rituals or interventions.

Summary

Literature on Western therapy and cross-cultural therapy have accounted for their widespread use but not without consideration for the cultures of non-Western peoples. Counselling and psychotherapy in New Zealand and Singapore are also based mainly on Western therapy models and interventions. The next section considers their influence on the mental health training and practices in New Zealand and Singapore.

Influence of Western Therapy in New Zealand and Singapore

New Zealand

New Zealand psychology has its origin in British empiricism and a North American professional orientation. In the past, it was influenced by the psychoanalytic theory in spite of the emphasis of experimental psychology. In 1961, the first course in clinical psychology was established as a post-graduate programme. From the 1980s, psychotherapy training was conducted as part of training in clinical psychology emphasising the scientist-practitioner model and cognitive-behavioural orientation. Clinical psychology has also taken on an assessment and psychometric perspective (Blampied, 1999; Evans, 2002). Presently, six postgraduate clinical psychology training programmes are conducted by psychology departments of the various universities in

New Zealand (Evans, 2002). Subsequently, a study by Patchett-Anderson (1997) showed that over half the clinical psychologists in New Zealand identified themselves as practising from a cognitive-behavioural orientation. Another study by Kazantzis & Deane (1998) found that New Zealand psychologists used cognitive approaches more often than British or North American psychologists, but less behavioural and psychodynamic approaches than them. Despite the emphasis of cognitive-behavioural approaches, other theoretical approaches were also taught within most programmes in various universities, for example, systemic approaches as part of child and family therapy training (Kazantzis & Deane, 1998).

Some researchers in New Zealand, however, commented that its training programmes in psychology are still lacking in terms of cross-cultural competence (Johnstone, 1997; Taufa, 1996). For example, the Māori psychological approach to understanding and treatment of abnormal states of mind are excluded (Ritchie & Ritchie, 1999; Stewart, 1995). Conversely, an evaluation by Nathan, Wilson, and Hillman (2003) found that CBT treatment protocols that have incorporated kaupapa Māori had demonstrated superior efficacy in treatment outcomes compared to CBT used on its own.

By the turn of the new millennium, among MHPs in New Zealand, there were 481 psychiatrists (Medical Council of New Zealand, 2004), 1,404 registered psychologists (New Zealand Psychologists Board, 2004), 2,500 counsellors (New Zealand Association of Counsellors, 2004), and an estimate of hundreds of social workers and psychotherapists. This has not included therapy-trained general practitioners in primary health care, whose numbers are not available.

Singapore

Counselling is the common term used among formally trained Singapore MHPs like counsellors, family therapists, general practitioners, psychiatrists, psychologists, psychotherapists and social workers (Sim, 1999). Psychotherapy is the lesser-used term probably because it is not developed fully in Singapore (Ang, 1999), or that "therapy" is preferred.

Singaporean researchers have traced the encouraging development of psychology and Western therapies in Singapore (see for details, Ang, 2001; Banerjee, 1999; Chong & Ow, 2003; Elliot, 1999; Long, 1984; Sim, 1999; Yeo, 1993). Notably, formal training in psychology or Western therapy for Singapore MHPs is either done locally or overseas. Some of the overseas countries which Singapore MHPs had their formal training in psychology or Western therapy include Australia, Britain, New Zealand, and the United States (Ang, 2001; Lee, 2002; Long, 1984). If they were locally trained in therapy, it would be also in Western models and approaches (Elliot, 1999). As no formal clinical psychology programmes are available in Singapore, therapy training it is carried out by way of supervision (Elliot, 1999).

Interestingly, Western therapy has gained inroads into the highly regarded biomedical model through public information and provision of allied mental healthcare services. Among MHPs, it was generally agreed that family doctors, psychiatrists, psychologists, counsellors and medication are helpful in treating depression, schizophrenia and mania (Parker, Mahendran, Yeo, Loh, & Jorm, 1999; Parker, Lee, Chen, Kua, Loh, & Jorm, 2001). A number of studies have shown the efficacy of Western therapy with Singaporeans. For example, Ang's (2001) study showed that reassurance was a suitable technique used in psychotherapy regardless of the cultural background of Singaporean clients. Devan's (2001) study also showed the possible use

of moderated psychodynamic group therapy with Singaporean clients. Another study by Bentelspacher, DeSilva, Goh, & LaRowe (1996) showed that psychoeducational group treatment worked for Singaporean families caring for a mentally ill relative.

By the turn of the new millennium, among MHPs in Singapore, there were 97 psychiatrists (Singapore Medical Association, 2003), over 300 psychologists (Singapore Psychological Society, 2004), 73 registered social workers (Singapore Association of Social Workers, 2004) and an estimate of hundreds of counsellors and psychotherapists. Therapy orientations of Singapore MHPs were mainly behavioural, cognitive, psychodynamic and systemic (Ho, 2000; Soong, 1997). A survey of Singapore MHPs by Ang (2001) found that most psychiatrists endorsed the psychodynamic orientation, whereas counsellors, psychologists and social workers endorsed the cognitive behaviour and eclectic orientations equally.

Common Use of Diagnostic System and Assessment Procedures

As MHPs of both New Zealand and Singapore are trained and practised in Western therapy models and interventions, it is highly likely that they would also be using the accompanying Western diagnostic systems and assessment procedures for diagnosis, classification and treatment of mental disorders of their clients.

The DSM

The DSM (Diagnostic and Statistical Manual; American Psychiatric Association, 1994) is a common diagnostic system or guide used by Western-trained therapists on the diagnosis and classification of mental disorders. Again, as with Western therapy, it has received differing feedback from researchers and users on its

applicability across cultures. On the one hand, for example, Lo´pez and Guarnaccia (2000) commended that the DSM had included cultural influences on the expression, assessment and prevalence of specific disorders, an outline of a cultural formulation of clinical diagnosis, and a list of relevant cultural-bound syndromes. Chen, Wong, Lee, Chan-Ho, Lau, and Fung (1993) found that the DSM was suitable with classification of mental disorders of people in Shatin, Hong Kong. Furthermore, Weissman, Bland, Canino, Faravelli, Greenwald, Hwu, et al. (1997) found that the clinical description of panic disorder was relatively consistent in Canada, France, Italy, Korea, Lebanon, New Zealand, Puerto Rico, United States, and West Germany, except Taiwan. The exception with Taiwan, in which the DSM was widely used, was possibly due to cultural reluctance to endorse mental symptoms. An international study (Sartorius, Ustun, Silva, Goldberg, Lecrubier, Ormel, et al., 1993) by the World Health Organisation found that major psychological disorders of mood, anxiety, somatoform disorders, and neurasthenia were common in Brazil, Chile, China, France, Greece, Germany, India, Italy, Japan, Netherlands, Nigeria, Turkey, United Kingdom, and the United States; thus, demonstrating the applicability of DSM diagnostic criteria in establishing clinical thresholds for psychological disorders across cultures. On the other hand, Thakker, Ward and Strongman (1999) contended that the DSM was not suitable with non-Western cultures, and had instead counter-proposed a constructive perspective for the diagnosis and classification of psychopathology for these cultures.

To assist in treatment planning and making diagnoses on psychiatric disorders or major Axis I of the DSM, the SCID (Structured Clinical Interview for DSM) was designed. It is a semi-structured interview administered by a clinician, and it includes an introductory overview followed by modules representing the major Axis I diagnostic classes. It guides the clinician in testing diagnostic hypotheses as the interview is

conducted. The output of the SCID is a record of the presence or absence of each of the disorders being considered, for current episode (past month) and for lifetime occurrence (Spitzer,Williams, Gibbon, & First, 1992). In addition to the SCID, new instruments for measuring comorbidity with major disorders of Axis I of the DSM are also designed. For example, the Structured Clinical Interview for the Spectrum of Substance Use (Sbrana, Dell'Osso, Gonnelli, Impagnatiello, Doria, Spagnolli, et al., 2003), and the Structured Clinical Interview for DSM-IV Dissociative Disorders—Revised (Steinberg & Hall, 1997). There is, however, little emphasis on the use of the SCID and its variants in the studies conducted in New Zealand and Singapore.

Psychological Assessment Procedures

Studies have also found the universal use of psychological assessment procedures across different cultures. For example, the Hebrew version of the Psychotherapy Expectancy Inventory was found valid in Israel (Wallach & Farbshtein, 2001). The Korean and Chinese versions of the Centre for Epidemiologic Studies-Depression Scale were found valid respectively with Koreans and Chinese (Noh, Kaspar, & Chen, 1998). The exception to this Scale was that these Asians were reluctant to endorse items that elicit subjective experiences of positive affect. In other words, when depressed, these clients did not give emphasis to positive feelings as a means of coping with negative experiences. The Eysenck Personality Questionnaire had been standardised on Arab patients (El-Islam & Abdel-Razek, 1993). Personality disorders were reliably assessed with the International Personality Disorder Examination (a semi-structured clinical interview compatible with the DSM) in 11 countries in Africa, Asia, Europe and North America (Loranger, Sartorius, Andreoli, Berger, Bucheim, Channabasavanna, et al., 1994). The Cantonese, Vietnamese and Laotian versions of the

Affect Balance Scale were found culturally equivalent to the English-language version (Devins, Beiser, Dion, Pelletier, & Edwards, 1997). The Chinese version of the Schedules for Clinical Assessment in Neuropsychiatry was found valid in Taiwan (Cheng, Tien, Chang, Brugha, Cooper, Lee, et al., 2000). Olson's (2001) research provided a list of commonly used psychological tests, but Esters and Ittenbach (1997) questioned the effectiveness of IQ tests in their review of their application in multicultural societies. In general, psychological assessment procedures have found their use with many cultures.

Summary

Taken together, mental health practices in New Zealand and Singapore have been influenced by Western therapy models and interventions, and the accompanying diagnostic system and psychological assessment procedures. The main difference identified thus far is that New Zealand is better equipped for clinical psychology at the tertiary institutions. The question here is how suitable is Western therapy with multicultural clients, aside from their peculiarities in managing their mental health. From personal experience and observations while working with psychiatric clients, four factors stood out from the many therapist-client factors from multicultural clients that would likely influence the therapeutic alliance or relationship: gender and ethnicity of therapist and client; therapist self-disclosure; handling of religious or spiritual issues; and attitudes towards use of traditional healing practices by clients. They are discussed in the next section.

Factors influencing the Therapeutic Alliance

Gender and Ethnicity of Therapist and Client

Much has been written, among other characteristics, on matching the gender or ethnicity of therapist and client to enhance the success of therapy. Understandably, it is expected that such a match in the expectations of treatment would not only increase the appeal of therapy to clients but also of mental health services. However, clinical therapy trials on these studies are absent and empirical support for such ethnic matching is inconclusive (Karlsson, 2005). For example, a study by Bryan, Dersch, Shumway and Arredondo (2004) showed that there was no difference between gender or ethnicity matches on perception of outcome in therapy. A meta-analysis of 10 published and unpublished studies between 1991 and 2001 by Shin, Chow, Camacho-Gonsalves, Levy, Allen, and Leff (2005) found no significant differences whether clients and clinician were ethnically-matched with respect to overall functioning, service retention, and total number of sessions attended for African American and Caucasian American adult populations in mental health services. Another study by Shafi (1998) did not find it necessary for Asian Muslim women clients to be ethnically matched with their counsellor, whereas Samion (1999) recommended the opposite.

McCabe's (2002) study found that client-therapist ethnic match was a significant predictor of dropout rate in therapy. A study by Wintersteen, Mensinger, and Diamond (2005) found that gender-matched dyads reported higher alliances and were more likely to complete treatment, and ethnic matching predicted greater retention. A study by Halliday-Boykins, Schoenwald, and Letourneau (2005) found that youths whose caregivers were ethnically matched with their therapists demonstrated greater decreases in symptoms, longer times in treatment, and increased likelihood of discharge for

meeting treatment goals. In addition, for youths whose caregivers were of mixed ethnic heritage, caregiver-therapist ethnic match was associated with greater improvements in psychosocial functioning.

Barring exceptions to gender issues like sexual dysfunction (Dienhart, 2001) and ethnic issues like customary rites (Ancis & Szymanski, 2001) that could be better managed by same gender or ethnic therapist-client dyads, there seems to be few issues that the therapist and client cannot discuss within the ethical realm of therapy. In other words, the gender or ethnicity of the therapist and client is less of a concern. Perhaps, the concept of "cognitive match" proposed by Zane, Sue, Chang, Huang, Huang, Lowe, et al. (2005) provides a better explanation of therapy outcomes. Accordingly, this so-called "cognitive match" is notably related to positive attitudes towards the therapy sessions, a reduction in avoidant coping behaviours, and an improvement in psychosocial functioning. Hence, even when the therapist and client were not ethnically matched, therapeutic achievements would be made if the therapist and client share similar perceptions of the presenting problem, client's coping style, and expectations about treatment goals. These findings have concurrence from a study by Kim, Ng, and Ahn (2005) who found specifically that common worldviews of the therapist and client in the cause of the problem enhanced the therapeutic relationship.

Therapist Self-disclosure

Published literature on therapist self-disclosure were almost absent before 1980 (Mahrer, Fellers, Durak, Gervaize, & Brown, 1981). Even present research suggests that it is an infrequently used intervention in psychotherapy (Burkard, Knox, Groen, Perez, & Hess, 2006); this is not surprising, as the purpose of therapy is on resolving the client's problem. As defined in the article by Mahrer, Fellers, Durak, Gervaize, and

Brown (1981), self-disclosure included contents as telling the client about the therapist's current and personal life, about the therapist's involvement with the client's problem symptoms, about therapist's immediate emotions, fantasies, and bodily phenomena, and about what the therapist is seeking to do in therapy. Put simply, therapist self-disclosure is defined as therapist statements that reveal something personal about therapists (Burkard, Knox, Groen, Perez, & Hess, 2006).

Some studies have shown the effects of therapist self-disclosure. On the one hand, self-disclosure might be a tool for providing insight overcoming the client's therapeutic impasse or to bridge the gap between the therapist and client (Boller & Lee, 1997; McEachern & Kenny, 1999). In other words, it could enhance the therapeutic relationship (Bentelspacher, DeSilva, Goh, & LaRowe, 1996; Inskipp, 2000) or overcome relational conflicts with clients (Ballen, 1999). On the other hand, self-disclosure could violate the therapeutic boundary and relationship.

On a related context, Mahrer, Fellers, Durak, Gervaize, and Brown (1981) found that the consequence to therapist self-disclosure, following the client's statements signifying a negative relationship with the therapist, was neither a reciprocal self-disclosure nor a positive relation with therapist, rather a turning to external figures, objects and situation. Interestingly, Inskipp (2000) concluded that therapists could not help but self-disclose through responses or not (perhaps, through body language), and recommended that self-disclosure should be brief and not made early in session.

Religious or Spiritual Issues

The past 25 years have seen people describing themselves as both religious and spiritual, indicating that spirituality represents an expanding conception of religion (Emmons & Paloutzian, 2003). Furthermore, with multiculturalism, the needs of

religious clients are becoming more prominent and an acceptable focus of research and treatment (Hall & Hall, 1997). According to Miller (2003), spirituality encompasses experiences, beliefs and practices, is linked to religion, and spiritual life can be enhanced with rituals. Thorne (2000), however, sees spirituality as part or central part of an individual's quest for personal growth and autonomy, and religion has about it the ring of oppression, conformity and self-negation. Nevertheless, religious coping behaviours assist people during stress and illness. Examples of religious treatment techniques include bibliotherapy, focusing technique, imagery, prayer, journal writing, meditation, rituals, relaxation, use of sacred writings (e.g., Buddhist scriptures), and working closely with religious leaders in community. With regard to psychology and religion, MHPs have traditionally been seen as part of the process of secularization of modern culture. A study by Smith and Orlinsky (2004) found that though the predominant religious background of 975 international psychotherapists from New Zealand, Canada, and the United States was Christian, many would not indicate their affiliation. The study showed that the nature of religiosity among psychotherapists was complex, and contended the dominant image of the psychotherapist as someone who would be adamantly secular and critical of religion.

Between therapy and spirituality or religion, there are bridges as well as barriers (Thorne, 2000). For example, a client's spirituality might become an important ally in the therapeutic process (Cornett, 1998). The incorporation of religious or spiritual beliefs, values and methods into the process of psychotherapy is advocated because more and more people seemed to prefer religious-sensitive psychotherapy, and religious material might be unavoidable in therapy (Hall & Hall, 1997). Furthermore, for the therapist who shares the same religious tradition and spiritual heritage as the client, prayers could be vital in promoting a more holistic, psycho-spiritual development. A

new avenue for the clinical application of spirituality could come from the bio-psychosocial-spiritual model that is operationalised through a description of Buddhist psychotherapy (Berman, 1999). Christian MHPs in Singapore were found to show an inclination towards the integration of psychology and theology (Ng, 1999). On the other hand, religious therapists tend to avoid discussions that would contradict their religious beliefs (Joseph, 1993). However, countertransference from religious therapists could result in, for instance, the evangelisation of a client (Case, 1997).

On a related context, a study by Misumi (1993) found that Christian Asian Americans and Christian Caucasian Americans preferred pastors for spiritual problems, and both had lower preference ratings for non-Christian professionals. Psychologists who affirmed Christian beliefs tend to endorse the cognitive behaviour orientation because of the absence of metaphysical ideology between them, whereas those who affirmed Eastern and mystical beliefs tend to endorse humanistic and existential orientations (Bilgrave & Deluty, 1998). These psychologists, who considered their religious beliefs personally important, used these beliefs to guide their practice of psychotherapy, and conversely, used their practice of psychotherapy to modify these beliefs. However, how therapists handle religious issues in their own therapy was more important, which could then change they way they manage their clients (Sorenson, 1994).

Researchers have proposed ways to manage religious or spirituality issues in therapy. For example, Zinnbauer and Pargarment (2000) advocated using the constructive and pluralist approaches to work with diverse clients and religious beliefs. The constructive approach denies the existence of an absolute reality but recognises the ability of the individual to construct his or her own personal meanings and realities. The pluralist approach recognises the existence of a religious or spiritual absolute reality but

allows for multiple interpretations and paths towards it. Greenberg and Witztum (1991) proposed guidelines for working with strictly religious patients, which included: cooperate with patient's spiritual mentor to reduce patient's resistance to therapy; examine therapist's religious attitudes to modify countertransferential feelings; and acquire knowledge of patient's religion.

Traditional Healing Practices

Traditional healing practices have long existed for all cultures. For example, Caucasians would use services of pastoral counsellors and religious exorcists, Chinese would use the services of herbalists, temple mediums, shamans and acupuncturists, Indians would use the services of Ayurvedic healers and temple mediums, Muslims would use the services of herbalists, bomohs, pawangs and dukuns (the latter three are traditional healers), and Māori would use the services of kaumatua (spiritual leaders) and tohunga (traditional healers) (Deva, 2004; Lee, 2002, McLeod, 1999). Even today, traditional healers continue to treat a large variety of mental health problems, including anxiety, depression, substance abuse, and family dysfunctions with the help of rituals, attaining treatment outcomes equivalent to those of Western psychotherapists (Al-Krenawi, 1999).

On the important side issue of rituals, Al-Krenawi (1999) noted that major works in psychoanalytic, Jungian, and existential psychotherapy had paid considerable attention to the therapeutic power of healing rituals, first from ambivalence then to recognition. Moreover, contemporary strategic therapy, social work and pastoral counselling have unequivocally acknowledged the therapeutic benefit of healing rituals. The advantages of the accepted therapeutic use of ritual include: skirting doubts on insight-oriented "talking therapy", circumventing the demand for articulation and

introspection in therapy, relying on actions of rituals than words in therapy gives form to emotions, and enabling the therapist to act in accord with his or her traditional clients' expectations of an MHP. By giving their clients ritual "assignments" and in directly leading them in ritual acts, the Western-trained therapist can behave in ways similar to the traditional healer and accepted by the population. At the same time, rituals can focus, structure, and shorten the time of therapy, and being a right brain activity, rituals touch the unconscious more quickly than verbalization. The integration between non-Western and Western ritual may also lead to positive treatment outcomes.

The argument here is that traditional healing practices and rituals have real and acknowledged value as a therapeutic tool, whatever the client's cultural background, and that their uses in cross-cultural therapy may have the added benefits of inducing clients who might otherwise reject the intervention to accept it and of improving collaboration between client and practitioner. Guidelines to the use of traditional healing practices with multicultural therapy are available in literature (e.g., Sue & Sue, 1999). Among the guidelines was an urge to the therapist to be willing to seek the advice of traditional healers, and that spirituality must be seen as a legitimate aspect of mental health. In addition, the therapist should treat the client's traditional healing practices with due respect, solemnity and, if need be, mysticism.

In New Zealand, researchers had recommended that the diagnosis and treatment of Māori clients be collaborated with their traditional healers because they view health, illness and healing from an holistic approach, and embrace spiritual beliefs and values that provided an explanation to the origin of Māori illness (McLeod, 1999; Paewai, 1997). In Singapore, Lee (2002) found that Chinese Singaporean clients held eclectic belief systems from traditional healing practices (e.g., traditional Chinese medicine, shamanism and geomancy) and Western therapy (e.g., psychodynamic and behavioural

therapies). Moreover, Walsh (1995) noted an increasing number of Western MHPs are now using yoga and meditation. West (1997) indicated that some experienced psychotherapists and counsellors in Britain were including traditional healing practices in their therapy because of benefits to health from spiritual experiences and development.

Summary

Discussion of the four factors—gender and ethnicity of therapist and client; therapist self-disclosure; handling of religious or spiritual issues; and attitudes towards use of traditional healing practices by clients—highlights the complexity of multiculturalism and its effects on Western therapy. Given New Zealand's population of 69% Caucasian ethnic groups, Western therapies would seem adequate, but with the growing 31% of non-Caucasian groups, cross-cultural therapy would be needed. Given Singapore's population of almost 98% non-Caucasian ethnic groups, the efficacy of Western therapy and cross-cultural therapy would need to be investigated. Many questions arise for mental health practices in New Zealand and Singapore. For example, is the treatment protocol for mentally ill clients in both these countries consisting of medical management, counselling and psychotherapy, and rehabilitation? How efficacious are Western therapy and cross-cultural therapy with New Zealanders and Singaporeans? Have they been modified for local use especially with non-Caucasian ethnic groups? How have MHPs coped with multicultural clients in their practices? What factors or skills have been found among MHPs that are helpful in therapy? Is there an existing indigenous therapy model in use in New Zealand and Singapore? How do MHPs cope with traditional healing practices of their clients?

Perhaps, a review of comparative studies on the characteristics, practices and experiences of MHPs in various countries may shed some light to these questions.

Comparative Studies on Characteristics, Practices and Experiences of MHPs

Research on counselling and psychotherapy have not only focussed on the efficacy of treatment approaches on specific disorders (Lambert, 2004), but also on the characteristics, practices, or experiences of MHPs. Many studies investigated one or more therapy-related concerns of a particular group of MHPs within their country. For example, Young (1993) surveyed theoretical trends of American counsellors. Newell and Gournay (1994) surveyed the clinical practice of British nurse therapists. Kelly (1995) surveyed value orientations of American counsellors. Hollanders and McLeod (1999) surveyed theoretical orientation and practice of counsellors in Britain. Ang (2001) surveyed views of Singapore MHPs on psychotherapy. Le Fevre and Goldbeck (2001) surveyed views of Scottish psychiatrists on CBT. Norcross, Hedges and Castle (2002) surveyed demographic characteristics, professional activities, theoretical orientations, and career experiences of American psychologists. Katz, Juni and Matz (2003) surveyed and compared values of New York psychoanalytic psychotherapists in 1979 and 1993. Soffe, Read and Frude (2004) surveyed views of clinical psychologists in Wales on service user involvement in mental health services. McClure, Livingston, Livingston and Gage (2005) surveyed the attitudes of Texas psychotherapists on managed care, internet counselling and theoretical orientation.

A series of studies investigated the experiences of MHPs within a country or between two countries: Parker, Mahendran, Yeo, Loh, & Jorm (1999) surveyed Singapore MHPs on diagnosis and treatment of mental disorders; Parker, Chen, Kua,

Loh, & Jorm (2000) surveyed Singapore psychiatrists and other MHPs on mental health literacy; and Parker, Lee, Chen, Kua, Loh, and Jorm (2001) compared the mental health literacy indirectly between Singapore and Australian general practitioners. Yet another series of studies investigated psychotherapy training across Europe: Zerbetto and Tantam (2001) surveyed European practitioners on psychotherapy modalities; Van Deurzen (2001) surveyed psychotherapy training in European countries; and Tantam, van Deurzen, & Osterloh (2001) surveyed barriers to psychotherapy training in Europe.

Perhaps, the most extensive research examining characteristics, practices and experiences of psychotherapists within a country is the series of studies by the Collaborative Research Network of the Society for Psychotherapy Research, which focuses on the development of psychotherapists (Orlinsky, Ambühl, Rønnestad, Davis, Gerin, & Davis et al., 1999; Orlinsky & Ronnestad, 2005). Over the past decade, data on characteristics, practices and experiences of over 5,000 MHPs by this Network have included those from Argentina, Austria, Belgium, Brazil, Canada, China, Denmark, Egypt, England, Finland, France, Germany, India, Israel, Italy, Mexico, the Netherlands, New Zealand, Norway, Poland, Portugal, Russia, South Africa, South Korea, Spain, Sweden, Switzerland, and the United States (Bae, Joo, & Orlinsky, 2003; Orlinsky & Ronnestad, 2005). Particularly for Australia, New Zealand and North America, data on characteristics and theoretical orientations of their psychologists were collected by a study by Kazantzis and Deane (1998).

In summary, numerous studies have examined the characteristics, practices and experiences of MHPs in different countries, and have provided data for comparisons in one way or another. The most consistent set of comparative data comes from the series of studies by the Collaborative Research Network of the Society for Psychotherapy Research. In line with the above studies, this study attempts to do the same but with

additional aims. First of all, it will compare data between New Zealand and Singapore directly, in which case, participating MHPs will actually be informed of the intention to match their data for the benefits to both groups. Secondly, it will elicit experiential skills from participating MHPs about their managing of clients, in particular, Chinese clientele. This second aim further investigates the efficacy of Western therapy with Chinese clientele, which is the subject of the next discussion.

CHAPTER 3

CHINESE CLIENTELE & THERAPY

This chapter begins with a broad review of the literature on the psychology of Asians, and then specifically on the psychology of Chinese people. Psychological profiles of Chinese New Zealander and Singaporean clients are then examined briefly, with a view of their influence on the mental health practices in their respective country.

Psychology of Asians

Chinese individuals in Western countries are often referred to as Asians even though the composite Asian group consists of many different ethnic and cultural groups. Perhaps, the reference is appropriate where common features of Asians are concerned. Thus, "Asian-ness" is briefly defined here, to be followed by descriptions of salient examples of this concept.

Accordingly to Inoguchi and Newman (1997), the phrase "Asian values" implies presumptuously that the social, economic and political characteristics of certain Asian countries are based upon an identifiable, shared value system which transcends national, religious and ideological differences. Certain cultural traits are overt. A primary characteristic of Asian societies is that they are based upon group orientation or collectivism—the interests of the community are felt to come before those of the individual. Consequently, Asians work for the good of society, are less selfish and accept that the cohesion and stability of society are more important the rights of individuals. Behaviour is motivated primarily by equal duties and responsibilities and not by concerns of individual rights. Collectivism is also associated with values such as

self-effacement, self-discipline and personal sacrifice to the greater good (Chu, 1999; Inoguchi & Newman 1997; Oga, 2004).

Collectivism is integral to the matrix of conformity to norms, maintenance of interpersonal harmony, public morality, humility, teamwork, deference to authority figures, hierarchical family structure, filial piety, frugality, hard work, recognition through achievement, and emotional self-control (Chu, 1999; Inoguchi & Newman 1997; Kim, Ng, & Ahn, 2005; Lippincott, 1999; Oga, 2004). Asian families generally share a patrilinear and hierarchical structure in which the oldest males have the authority. Sons are valued to carry on the family name. Asian women's cultural values are to be gentle, quiet, willing to serve and please others. Child-rearing practices tend to be moralistic than psychological. Parents tend to discourage their adolescent children from dating and developing intimate relationships early, so that educational achievement is not distracted. Strong ties are maintained with nuclear family, and welfare of family comes before that of individual members (McEachern & Kenny, 1999).

Emotional restraint is emphasised in Asian families. Overt displays of emotions are seen as disruptive to family unity and peace, and signs of immaturity. Open discussion of sexual matters is considered taboo. Communication is action-oriented, one-way from authority figure to layman. Silence and avoidance of eye contact are signs of respect, also to maintain harmony through perseverance and stoic acceptance of suffering (Chu, 1999).

Different Asian cultures manifest mental distress differently, and in their appraisals and management of these manifestations. For example, a study by Ball, Mustafa, Moselle (1994) found that young Muslim adults coped with their problems through praying and control of emotions. In other words, they simply referred to the

"The Will of Allah" and derived comfort from that belief. Notably, Muslims rated Allah (their God) and prayer higher than any other religious issues (Edman & Koon, 2000). Furthermore, most Muslim patients would have visited their traditional healer before consulting a psychiatrist for their mental illness (Razali & Najib, 2000). As for stressful East Indians, the exhibition of possession syndrome was a socially acceptable coping behaviour (Shobhadevi & Bidarakoppa, 1994). In Chinese and Vietnamese cultures, ghosts or spirits played a role in human dealings, and a person who experienced feelings of fear, anxiety or depression might assume that his or her home was haunted. The guidance from elders to children when they faced feelings of frustration or anxiety was simply "don't think about it", as thinking would lead to negative experiences of affect (Sue & Sue, 1999).

By and large, help-seeking behaviours of Asians are determined by their cultural causal beliefs of mental illness (Sheikh & Furnham, 2000), some of which are already mentioned. Furthermore, Asians tend to solve psychological problems preferably on their own, relying on family members, close relatives, and friends, or traditional healing practices rather than with MHPs (Ngai, Latimer, & Cheung, 2000). Thus given their cultural dispositions, Asian clients might be perceived by the Western therapist as dependent, unable to make decisions on their own, lacking in maturity and possibly repressed (Sue & Sue, 1999). Consequently, a lack of understanding of Asians may lead to perception of myths, images and stereotypes.

With development and modernisation, many Asian countries have developed and changed. The degree of change among Asians depends in part on the geographical area, government, and environmental influences. Publications on Asian societies are plentiful and full descriptions are beyond the scope here.

Psychology of Chinese People

Apart from the foregoing discussion on the psychology of Asians of which Chinese belong and share their psychological make-up, Chinese people do have specific characteristics, though not necessary peculiar to them. Salient examples of "Chineseness" are described here.

Chinese cultural identity is related to collective self-esteem (Kuo & Roysircar-Sodowsky, 1999). Traditional Chinese emphasise hard work, obedience, proper conduct, moral training and acceptance of social obligation among its people (Ho, 1986). Thus, there is a lack of emphasis on independence, assertiveness and creativity. External attribution for success or failure in interpersonal and person-object relationships may be embodied in the concept of fate, and predetermined, external control (Cheung, 1986). Traditional parenting patterns see leniency or even indulgence towards the infant or young child, but strict discipline being imposed on older children. The child's exploratory or risky activities are discouraged. Impulse control and physical aggressions are suppressed, especially towards authority are rarely expressed. Boys and girls are treated differently. The father is usually the disciplinarian than the mother; therefore, the father-child affectional distance is greater than the mother-child's. Thus, Chinese children tend to be less vocal, less active, less likely to smile, and more apprehensive in social separation situations, and disposed towards inhibition (Ho, 1986).

Among other important Chinese virtues are academic success, belief in spirits, face, filial piety, and moderation (Chu, 1999; Hong & Domokos-Cheng-Ham, 2001; Leslie, 1979; Thomas, 1990). High regard for education and academic success prevail in Chinese, and bring about much stress and anxiety in the individual, family, school and

society. The belief in spirits and ancestral worship is kept up through customary visits to graveyards and temples to protect the living from unseen hostilities. An illness may be attributed to the lack of this belief and presented as one being possessed. There is, however, a decreasing tendency among the young, English- and highly-educated Chinese to practise traditional rituals (Soong, 1997). Face means behaving to uphold one's self-esteem and family's name, the loss of face equates to a feeling of shame. As such, an individual or family with a mental illness may be unwilling to seek help from an MHP. Education and information is loosening this attitude, and more Chinese are aware of the availability of therapy services for their problems. Filial piety, related to face, entails loyalty, devotion, respect and obedience to one's parents, especially the father, and family's name. Moderation is the tendency to compromise. Chinese, however, may prefer to present disagreement or displeasure in an indirect manner, for example, unilateral termination of therapy by not turning up again.

Light on Chinese psychopathology can be shed from their classical and folk traditions (Cheung, 1986). In classical tradition, illness is discussed in terms of ying and yang, five fundamental elements, meridian system, and circulation of vital energy. Aetiology of illness is attributed to six seasonal influences (wind, heat, fire, cold, moisture and dryness), seven internal emotions (joy, grief, fear, anger, love hatred and desire) and situational conditions as trauma, fatigue, deregulation of diet, and insects. Folk tradition accounts for Chinese medicine, supernatural as well as Taoist beliefs of divination; sorcery, spirits, and ghosts are held responsible for illness. Fortune telling, astrology, physiognomy, geomancy and shamanism are traditional healing practices. Mental illness is a common reason for consultation with shamans and fortune-tellers. On manifestations of mental illness, there is high prevalence of somatisation among Chinese in response to stress in the form of headaches, headache, diffuse bodily aches,

insomnia, poor appetite, or a general feeling of physical or mental weakness (Parker, Chen, Kua, Loh & Jorm, 2000); hence, they present with cognitive anxiety at the clinic (Lippincott, 1999).

As a whole, the degree of change among Chinese people depends on the geographical area, personal or group preferences, environmental influences and acculturation. Publications on various Chinese societies abound and full descriptions are beyond the scope here (see, e.g., Chu, 1999; Hong & Domokos-Cheng Ham, 2001; Liu, Ng, Weatherall & Loong, 2000; Leslie, 1979 on details of Chinese culture). With the characteristics of Asian-ness and Chinese-ness in mind, the discussion turns to the psychological profiles of Chinese New Zealander and Singapore clientele.

Chinese New Zealander Clientele

Chinese from China and Hong Kong arrived in New Zealand in the late 1860s to work in the gold mines at the South Island (Williams, Graham, & Foo, 2004). The laws then restricted their residence, citizenship, and marriage. Removal of immigration barriers in 1986 saw considerable increase of Chinese migrants settling in New Zealand, especially in the last 15 years that made their presence pronounced. In New Zealand today, Chinese people make up the highest ethnic group among Asians (about half of the 9.2% of Asians; Statistics New Zealand, 2006). Unlike the earlier arrivals, recent Chinese migrants are more culturally and ethnically diverse. Many of them are well-educated, professional city dwellers or business people. However, those from societies that differ considerably from New Zealand's system find adjustment to life in New Zealand challenging and arduous. Challenges include poor English language skills, difficulty finding employment, changes in familial roles and social support systems, or

trauma experienced prior to immigration (Ngai, Latimer, & Cheung, 2000; Williams, Graham, & Foo, 2004). Generally, Chinese New Zealanders perceived health, family and employment as the most important things in their life.

The prevalence rate for mental illness of Asian migrants in New Zealand was no different from that of European New Zealanders. In the 1996 census, 21.5% of Chinese New Zealanders were found to have experienced depression, emotional problems or mental health problems (Ngai, Latimer, & Cheung, 2000). Strong stigmatisation on mental illness saw few receiving mental health services even less would self-refer, just like Chinese immigrants in the United States (Cheung, 1986). Slavet, Parker, Kitowicz, and MacDonald (2000) found that persons in psychotherapy and persons designated as mentally ill are seen as no different from each other—a perception often held by Chinese too. If help is sought, it is often when there is a crisis, or if they enter into treatment, it will be terminated prematurely. As mentioned, the non-participation rate of Chinese people in Westernised psychological treatment centres may lead to erroneous assumptions being made about their mental well-being or negative implications for those experiencing distress or mental health problems. It is most likely that symptoms of mental illness will not be identified. New Zealand MHPs have expressed concern that the stressors associated with migration and minority status may adversely impact the psychological adjustment of adolescent children of Chinese immigrants (Eyou, Adair, & Dixon, 2000). Chinese New Zealanders may internalise negative beliefs about themselves, have low self-esteem and desire to disown their ethnic heritage (Sandhu, 1999). As with Chinese Americans, stories on Chinese New Zealanders are over-emphasised, they are considered as successful and problem free and not in need of social programs designed to benefit disadvantaged ethnic groups (Sandhu, Kaur & Tewani, 1999). Thus, the presence of Chinese clients at the mental health centres in

New Zealand is seldom felt as they often confide in their families and friends or traditional healers with their mental illness. When their presence is observed, it is often at the emergency wards of hospitals when their symptoms are acute and at a critical stage.

Chinese Singaporean Clientele

A paper on this topic, titled "Counselling/Psychotherapy with Chinese Singaporean clients" was published in the Asian Journal of Counselling in 2006 (Foo, Merrick, & Kazantzis, 2006).[1] The gist of this paper is cited here.

Chinese Singaporeans make up 76.8% of the 4.48 million population of Singapore (Statistics Singapore, 2006). The 1996 Singapore Mental Health Survey revealed that Chinese Singaporeans had a 17.4% rate of minor psychiatric morbidity, mainly anxiety and depressive disorders. Other problems identified for them were addictive gambling, rising alcohol consumption among the younger adults, and a high elderly suicide rate due to depression and dementia (Kua, 2004). In spite of the abundance of information and services accessible on mental illness, many Chinese Singaporeans often attribute their occurrence to supernatural causes (Yeo, 2004), and still consider them taboo or mere bad fate. There is also the general apprehension that mental illness may be contagious, and that mental health services are associated with psychiatric care and medicine. Furthermore, mental illness is relegated second to physical illness, which is observable and often accorded immediate attention (Long, 1984; Hong & Domokos Cheng-Ham, 2001). For this reason, mentally ill Chinese

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[1] See No. 6 of Appendix U.

Singaporeans may appear at the clinic with symptoms of so-called somatisation—Chinese way of conceptualisation mental health (Lim & Bishop, 2000).

Help seeking behaviours of Chinese Singaporeans with mental illness would include first self-help, then seek help from relatives, friends or traditional therapies, and lastly, from MHPs (Ng, Fones, & Kua, 2003; Ow, 1998). Self-help strategies might include staying at home, taking tonic drinks, purging medicine, or vitamins, and going on special diets. Traditional healing practices sought after would likely be one or more of the following: acupuncture, aromatherapy, foot reflexology, fortune-telling, geomancy, herbal medicine, hypnosis, massage therapy, meditation, shamanism, and consultation with traditional healers—such as bomohs, temple liturgists, monks, ministers, and pastors (Long, 1984; Parker, Mahendran, Yeo, Loh, & Jorm, 1999). For example, a client may go to a medium to have his or her child's name changed because of the child's bizarre behaviours. Notably, the more conservative would still use herbal cures or seek the services of traditional healers before, during or after use of Western medicine, counselling and psychotherapy. Chinese Singaporeans who have consulted Chinese medicine doctors found them more caring and concern than Western-trained doctors (Lim & Bishop, 2000). Traditional healing practices, however, have been rated unhelpful by Singapore public MHPs for treatment of mental illness (Parker, Chen, Kua, Loh, & Jorm, 2000). In reality, fear and shame often caused them to avoid seeking help from MHPs until the problem became too severe or difficult to handle at home (Kee, 2004; Ng, Fones, & Kua, 2003; Ow, 1998), then professional help would be sought.

Nonetheless, psychotic illness gets a little more attention with Chinese Singaporeans. For example, Kua (2004) reported that the majority of patients with first-episode schizophrenia (80%) were referred to the National University Hospital within 6

months of the onset of illness. Yeo (2004) reported that about 24% of patients with first episode psychosis sought help from traditional healers at the first onset of symptoms.

Summary

Much has been said about the psychological make-up of Asians and Chinese in general, and Chinese New Zealanders and Singaporeans in particular. Existing literature has focussed on their traditional belief systems. Although Chinese New Zealand and Singapore clientele are discussed separately, they are not actually very different from one another. Existing data suggest that noticeable differences among Chinese are likely due to the different environments they live in. The question here is how well MHPs of New Zealand and Singapore have managed their Chinese clientele, and are there similarities or differences in doing so? The most commonly accepted psychotherapy and intervention is CBT. It is highly likely the case in New Zealand and Singapore. This is discussed next.

CHAPTER 4

COGNITIVE BEHAVIOUR THERAPY

This chapter review briefly the existing literature on CBT, highlighting implications on its increasing applicability with Chinese clients in general.

Cognitive Behaviour Therapy

Focus on outcome-based strategies has led to emphasis on therapeutic approaches and interventions that are responsive to clients' needs (Krieble, 2003). CBT is such an approach. Among its contributory therapeutic qualities are research-based, evidence-based, flexibility, theoretical practice tools, cultural sensitivity, and a common language for therapists (Merrick & Dattilio, 2006). CBT concerns various interventions that seek to reduce distress and enhance adaptive coping by changing maladaptive beliefs and providing new information-processing skills, based on the idea that cognition plays a role in the aetiology and maintenance of some psychological disorders (Lambert, 2004). It has fared well in controlled clinical trials, often proving superior to minimal treatment and at least equal to or superior to alternative psychosocial or pharmacological approaches across all age groups (Merrick & Dattilio, 2006). Every diagnostic disorder has been applied with CBT, including teaching psychotic clients to control their symptoms (Woolfe, Dryden, & Strawbridge, 2003). A survey by Young (1993) has found the following CBT techniques among the 20 frequently used counselling techniques of American counsellors: identify/challenge irrational beliefs, reframing, role playing, cognitive restructuring, imagery, coping self statements, and logical analysis of thoughts.

According to David and Szentagotai (2006), there are more than 10 types of CBT schools (e.g., cognitive therapy, cognitive-behavioural modifications, dialectic and behavioural therapy, meta-cognitive therapy, rational-emotive behaviour therapy, schema-focused therapy). However, regardless of the level of cognition differently defined by the CBT schools, the focus is on cognition, specifically, appraisal and knowledge of presumed facts. Knowledge of presumed facts or activating events is often analysed at the surface level as descriptions, inferences and attributions, and at the deeper level as schemas and other meaning-based representations. Appraisal is used to process knowledge of presumed facts for their relevance in personal well-being. With knowledge of presumed facts, CBT has reached prominence in the clinical field, but is loosing its heuristic value despite obvious accomplishments. The next phase of development into CBT's construct of appraisal and in cognitive psychology, however, could make CBT a platform for the integration of psychotherapy, above what it has already interfaced with other modalities (David & Szentagotai, 2006; Merrick & Dattilio, 2006).

Merrick and Dattilio (2006) have analysed the popularity of contemporary models of CBT in New Zealand, and postulated a number of influencing factors. First of all, government agencies, the health insurance industry and individual clients demand brief, cost effective solution-focussed interventions and professional accountability. Then, CBT has been effective in reducing psychological symptoms and relapse rates across a range of disorders, within a brief period of time, with or without medication. Furthermore, CBT provides the therapist with explanations of individual dynamics and fits into a viable model for treating individuals, as well as couples and families across diverse cultures (e.g. Māori clients). As for Singapore, the popularity of CBT there has not been formally assessed.

Literature and studies have shown that CBT has also gained acceptance with Eastern cultures and Chinese clients among the many approaches of Western therapy mentioned earlier—notwithstanding the lack of studies on Chinese clientele and these other therapy approaches. For instance, the recognition of CBT as an effective therapeutic approach was seen in the numerous presentations at the 1st Asian CBT Conference held in May 2006 in Hong Kong, which was jointly organised by the Chinese University of Hong Kong and the University of Queensland (Merrick & Dattilio, 2006). Findings from this study under the title, "Cognitive behaviour therapy in New Zealand and Singapore: From a doctoral study and personal experience" was published and presented there (Foo, Merrick, Kazantzis, & Williams, 2006).[2] In their twenty years of working with Chinese clients, Hong and Domokos-Cheng Ham (2001) concluded that the features of CBT (evidence-based, structured, problem-focused, present-focused, action-oriented, short-term psychotherapy), its principles and practice would appear to be compatible with the expectations favoured by Chinese people as it promotes self-help, is psycho-educational, and facilitates new coping skills to manage distressing cognitive and emotional problems. Its conceptual framework is also well-placed to take into account the idiographic nature of the client's problems in relation to cultural factors and the impact of immigration, somatic complaints, interpersonal relationships, and other areas of importance that impinge on the client's psychological well-being.

A study by Bentelspacher, DeSilva, Goh and LaRowe (1996) showed that cognitive-behavioural interventions like reframing, reinforcement and observational learning techniques were effective in managing cultural difficulties of contracting, self-disclosure and cognitive skill practice of Chinese clients. On the same note, Huat's

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[2] See No. 5 of Appendix U on its Abstract.

(1994) techniques of reframing, prescribing, and predicting a relapse used in the "therapeutic paradox" with Chinese clients paralleled cognitive restructuring and behaviour experiment techniques of CBT. A case study illustrating the use of CBT techniques with an elderly Chinese lady with generalised anxiety disorder has shown its effectiveness in helping her cope with her problems. Of importance, the case illustrated that Chinese dependent traits should not be seen as part of a dependent personality disorder. The case was presented at the 29th National Conference of the Australian Association for Cognitive Behaviour Therapy held in October 2006 in Australia, under the title "Cultural considerations for Chinese people: Implications for CBT". It was published in the New Zealand Journal of Counselling in November 2006, under the title, "Cultural considerations in using cognitive behaviour therapy with Chinese people: A case study of an elderly Chinese woman with generalised anxiety disorder", (Williams, Foo, & Haarhoff, 2006).[3]

The adaptation of the CBT 5-part model (Beck's model; Beck, 1995) for working with Chinese people has found approval among counsellors at the workshop held at the inaugural International Asian Health Conference in November 2004 in New Zealand, which was organised by the University of Auckland (Williams, Graham, & Foo, 2004).[4] Concise inputs from Chinese culture, values and practices were inserted into all five parts of the CBT 5-part model (Beck's model). The resultant diagram became a helpful device for explaining the contributing factors (affectional, behavioural, cognitive, biological/physiological, and environmental) to a Chinese client's mental problem. Overall response from the conference participants was that therapy conducted with Chinese New Zealand and Singaporean clients were similar to

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[3] See No. 4 of Appendix U.

[4] See No. 2 of Appendix U on details of the workshop cum paper.

those conducted on Chinese elsewhere in China, Hong Kong, Malaysia, New Zealand, Taiwan, and the United States of America. In other words, treatment of Chinese clientele far and wide with Western therapy would appear to be highly comparable.

Homework assignments constitute an interesting but necessary accompaniment to CBT. Their use mainly between sessions have enhanced therapeutic collaboration, tailored therapy to client's goals, and ensured that the benefits for the individual client are maintained in the long term (Kazantzis, Deane, Ronan, & L'Abate, 2005). Exceptionally, Chinese clients have been observed to adhere to completing therapy homework assignments. It appears that this was due to their cultural values and practices, customary problem solving process, and other traditional beliefs (Foo & Kazantzis, in press). A paper on this topic titled, "Integrating homework assignments based on culture: Working with Chinese patients" was accepted for publication in the Cognitive and Behavioral Practice in April 2006.[5]

Literature on CBT and Chinese clients, however, do sometimes create myths than knowledge. For example, in an article by Lee (2002), two clinical cases were cited to illustrate the integration of Western therapy methods with traditional behaviours of Chinese Singaporean clients. The first case involved a couple who could not get married because of what a fortune-teller had told the man's mother when he was young of his impending disaster if he should marry a woman of his potential wife's Chinese dialect. The solution, as recommended by Lee, was a revisit to the same fortune-teller who gave remedies for the couple to reverse their impending disaster should they tie the knot. The second case involved a Chinese man with an unexpressed grieving problem over his dead mother because of his difficulty in expressing emotions, and did not have someone to share it with. The client was asked by Lee to burn incense to his mother on a ghost

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[5] See No. 3 of Appendix U on its Abstract.

festival day, and to include a letter to his mum for his not being a caring son. That relieved him of his guilt for her. Lee commented that a Western family therapist would not have the cultural understanding and acceptance to do both recommendations. This is not accurate as cognitive behaviour therapists sensitive to cultures of clients could still resolve the cases, just like those in this study. In these cases, it is a matter of learning about the client's issues and then getting the clients to do behaviour experiments, to be followed with assisting the client in cognitively restructure their disturbing thoughts.

In another study, Chen and Davenport (2005) discussed the compatibility of Chinese characteristics, values and beliefs with CBT, and ascertained that with modifications, CBT would appear to be a practical model for working with Chinese American clients in short-term therapy. They, however, remarked repeatedly, that CBT was delivered to clients in a didactic manner, which was not an accurate portrayal of the principle and philosophy of this therapy approach—collaboration.

Summary

Taken together, Chinese people have their tradition, expectation, and treatment for mental health whether in New Zealand or Singapore. CBT has been implicated to be a choice of Western therapy for Chinese clients, though not without shortcomings. It is now left to evaluate and compare the application of Western therapy with Chinese New Zealander and Singaporean clients, with a view to finding similarities and differences in managing them by MHPs of both countries.

CHAPTER 5

PRESENT STUDY

This chapter presents the rationale and questions for the current research. Hypotheses are listed at the end.

Research Rationale

Comparable features of New Zealand and Singapore coupled with personal interest in applied psychology, particularly Western and Eastern psychotherapies, inspired this research. Commonalties between the two countries included the use of English as the common language, the availability of Chinese clientele, co-existence of Western and traditional beliefs and practices, and the growing demand for mental health care and services. The exceptional feature is the influence of Western and cross-cultural therapies in New Zealand and Singapore on their mental health development and practices, and the consequential use of accompanying diagnostic system, therapy interventions, and psychological assessment procedures. Of particular significance is the growing acceptance of CBT worldwide and its success with Chinese clients. Further inspiration for this research comes from the various studies that investigated the characteristics, practices and experiences of MHPs in different countries, and have provided data for comparisons in one way or another. Exemplifying is the series of studies by the Collaborative Research Network of the Society for Psychotherapy Research.

To iterate, this study aims to compare the characteristics, practices and experiential skills of New Zealand and Singapore MHPs in the hope of discovering

benefits for each other in the provision of counselling and psychotherapy services. Additionally, it will elicit experiential skills from participating MHPs about their managing of clients, in particular Chinese clientele. This second aim further investigates the efficacy of Western therapy with Chinese clientele.

On the basis of the literature described above, the following research questions and hypotheses are to be investigated.

Research Questions

Based on the foregoing discussion on New Zealand and Singapore, the influence of Western therapy, Chinese clientele and CBT, a series of research questions are generated for the study, and are presented for this investigation.

Given the common use of English, would there be a subtle difference in its usage by non-native English-speakers, especially with Singaporeans whose English is a "borrowed" language? Since therapy involves much operationalisation of client's issues, clarity of words used, summarisation and re-summarisation, and feedback, how different would it be with native and non-native English-speakers?

Given the growing non-Caucasian groups in New Zealand, how applicable would Western therapy be with these peoples? On the same note, given Singapore's population of predominantly non-Caucasian ethnic groups, how applicable too would Western therapy be with them? If Chinese clientele of both countries were the focus of attention, how similar or different were they in their cultural background and their reaction to Western therapy?

Given that Western and traditional beliefs and practices co-existed in both countries, how much of the latter would influence mentally ill clients when they attend

therapy? On the same note, how would Western-trained MHPs tolerate or accept these beliefs and practices?

Most importantly, if MHPs of both countries were presumably trained in and practised Western therapy, what would be the similarities and differences to their practice characteristics? Where and what exactly were the MHPs trained in? What therapy approaches would they have adopted in use in New Zealand and Singapore? Were these therapy approaches multicultural-friendly given the current emphasis in cross-cultural therapy? Was any modification done to the existing Western therapy models in use to suit the diverse clientele? If so, what kind of modifications? What were the similarities and differences among the therapy skills of MHPs? How satisfied would the MHPs be with the existing therapy approaches? What diagnostic system, therapy interventions, and assessment procedures were used in conjunction Western therapy? Were they universal or cultural-specific? Since CBT is gaining popularity in Western therapy, would the same be true for both these countries?

Since the focus is on Chinese clientele in New Zealand and Singapore, what would the MHPs have found out about the mental health profiles of these clients, their traditional cultural beliefs and practices, and perception and expectation of therapy and MHPs? Would therapist gender and ethnicity have an influence in the therapeutic relationship? Would MHPs have to self-disclose to clients during therapy? Would religion or spirituality of the client have a role in therapy? Would the use of traditional healing practices by a contributing factor in therapy? Did MHPs practise traditional healing practices as well?

Thus, this study plans to investigate the above questions with MHPs of both New Zealand and Singapore with forced-choice and open-ended questions to elicit the desired answers.

Hypotheses

Based on the series of research questions above, the following hypotheses are proposed:

Hypothesis 1 (Therapist Characteristics)

It has been argued in the foregoing discussion that both New Zealand and Singapore are modern multicultural societies with their share of mental health problems, and a growing demand for mental health care and services. It is hypothesised that personal, professional and practice characteristics of New Zealand and Singapore MHPs would be representative of their characteristics in their respective country. For example, the types of MHPs in service (e.g. counsellors, psychologists, psychiatrists), focus of practice (e.g. child, adolescent, adult), employment status (e.g. public or private), and work setting (e.g. inpatient, outpatient), including the ethnic ratio of their population (e.g. mainly Caucasian in New Zealand, mainly Chinese in Singapore).

Hypothesis 2 (Therapist Training)

It has been argued in the foregoing discussion that Euro-American models of psychology dominate Western therapy, but New Zealand is better equipped for clinical psychology at the tertiary institutions. Therapy training in Singapore is by way of supervision as no formal clinical psychology programmes are available. Singapore MHPs have had their formal training in psychology or therapy done locally or overseas. If they were locally trained, it is also in Western models and approaches. It is hypothesised that MHPs of both New Zealand and Singapore have been trained in

Western psychology and therapy, and that New Zealand is well established in clinical psychology.

Hypothesis 3 (Suitability of Western Therapy Models)

Western therapy models are designed for treatment of mental disorders of Westerners, and that the adaptation of these models for use entails the use of their accompanying diagnostic system, therapy interventions, and psychological assessment procedures. It is hypothesised that the application of Western therapy models with non-Westerners would entail some form of modification. These modifications would have been carried out by New Zealand and Singapore by MHPs on their non-Caucasian clients (e.g., Chinese clients), and especially for Singapore where mainly Asians reside. It is further hypothesised that if these models were suitable for treatment of non-Caucasian clients, there would be fewer clients' requests for therapist-client gender or ethnic match.

Hypothesis 4 (Diagnostic System)

The available literature suggests that Western therapy models and their accompanying diagnostic system and assessment procedures have been adapted for use by MHPs of New Zealand and Singapore. It is hypothesised that the presenting mental disorders of New Zealand and Singapore clients would be classified and diagnosed as according to the Western therapy model and system.

Hypothesis 5 (Therapist Self-disclosure)

With the growing demand for mental health care and services in New Zealand and Singapore, coupled with the multicultural nature of their clientele, especially indigenous people and Asians, it is highly likely that they would bring into therapy their traditional cultural practices and habits. For example, Chinese clients would often "get close" to the therapist with discussion of their personal issues. It is hypothesised that indigenous people and Asian clients would ask their therapists more personal questions, and that this would occur more often with MHPs in Singapore than would be with MHPs in New Zealand given the composition and nature of Singaporeans. It is further hypothesised that, since self-disclosure is not a practice in therapy and professional boundary is duly observed during therapy sessions, New Zealand MHPs would need to self-disclose less or were less accepting of self-disclosure than Singapore MHPs.

Hypothesis 6 (Religious or Spiritual Issues)

With the growing demand for mental health care and services in New Zealand and Singapore, coupled with the multicultural nature of their clientele, especially indigenous people and Asians, it is likely that they would also bring into therapy their religious or spiritual beliefs and practices. It is hypothesised that MHPs of both New Zealand and Singapore would frequently face religious or spiritual issues brought up by clients in therapy, especially from proselytes, or those who have found them helpful in coping with their life issues.

Hypothesis 7 (Traditional Healing Practices)

With the growing demand for mental health care and services in New Zealand and Singapore, coupled with conservative nature of indigenous people and Asians towards mental illness, it is very likely that such clientele would be making use of traditional healing practices (e.g., herbal cures and services of traditional healers) to treat their mental problems. It is hypothesised that as MHPs of both New Zealand and Singapore have been trained in Western psychology and therapy, they were likely not to accept the traditional healing practices of their clients while undergoing therapy, or would like them to be kept separate from therapy if clients would insist on continuing with those services.

Summary

Personal interest in Western and Eastern psychotherapies, particularly their application on Chinese clientele, supported by common features of New Zealand and Singapore and guided by existing studies inspired this research. This study will compare the characteristics, practices and experiential skills of New Zealand and Singapore MHPs to discover benefits for each other in the provision of counselling and psychotherapy services. Altogether, seven hypotheses were proposed for investigation. These include: identifying the personal, professional and practice characteristics of both New Zealand and Singapore MHPs; verifying their therapy training in Western models; investigating the suitability of Western therapy models with non-Caucasian clients; verifying the classification and diagnosis of mental disorders in these two countries; investigating the need for therapist self-disclosure, their management of religious or spiritual issues and traditional healing practices of clients.

CHAPTER 6

METHOD

This chapter presents the method for the present study covering participants, measures, design and procedure.

"Quantitative proponents aspired to realism, objectivity causal explanation and universal truth, whereas qualitative advocates emphasized the interpretive, value-laden, contextual and contingent nature of social knowledge" (Somekh & Lewin, 2005, p. 274). The strengths of the quantitative research are that its methods produce quantifiable, reliable data that are usually generalisable to some larger population. It falls short when the phenomenon under study is difficult to measure or quantify. The greatest weakness of the quantitative approach is that it "removes" human behaviour from the real world setting and disregards the effects of variables that have not been included in the model. Whereas qualitative research provide the researcher direct interaction with the people under study. The advantage of using qualitative research is that its methods generate rich, detailed data that leave the participants' perspectives intact. Its main disadvantage is that data collection and analysis may be labour-intensive and time-consuming. In addition, these methods are still gaining mainstream acceptance by researchers.

To overcome the strengths and weaknesses of the quantitative and qualitative research methods, a mixed design was chosen for use in this study. It comprised a mail questionnaire survey (Study I) and a structured interview (Study II) conducted in two phases. The intention of the mixed design was to complement and possibly integrate quantitative data (through descriptive analysis) with qualitative data (through content

analysis) so that cross-validation of responses and in-depth examination into the investigated variables of the study can be made. Furthermore, giving participants the choice of answering forced-choice questions as well as open-ended format ones was definitely more enlightening.

As Woolfe, Dryden and Strawbridge (2003) suggested, the one-on-one interview represents a flexible technique for gathering accounts of experience. Todd, Nerlich and McKeown (2004) offered many reasons for the use of a mixed design. Two key reasons are to improve the communication between academics and practitioners, and to explore different levels of the same phenomenon. Elaborating on the second reason, if two methods used have different strengths and weaknesses but which yield similar results, it increases confidence that those results are a true representation of the investigated phenomenon. For example, a set of interviews could help to produce a theoretically plausible explanation and make sense of the data from a questionnaire. They have even coined the word "qualiquantology" to express the mix.

Participants

For both phases of this study, target participants were New Zealand and Singapore MHPs who were formally trained in counselling and/or psychotherapy; namely, counsellors, psychiatrists, psychologists, psychotherapists and social workers.

Selection of Participants

The selection of target participants for this study was a rather complicated matter. It would be ideal to have the registered professional listings of the MHPs for selection of individual target participants. However, not all groups of MHPs in both

New Zealand and Singapore had to be registered for practice at the time of this study. Only two such listings were available: the List of Registered Clinical Psychologists for New Zealand and the List of Registered Psychiatrists for Singapore. Consequently, the selection of target participants had to be drawn as well from all organisations that distinctly offered counselling and psychotherapy services. The services of these organisations were published in electronic or printed media in both countries. Most of these organisations, however, did not identify their MHPs individually, rather as a multi-disciplinary group consisting of an undisclosed number of these members (e.g., a government District Health Board had a few psychiatrists, psychologists and social workers; or a private therapy centre had a psychiatrist and some psychotherapists). A few, though, did indicate the job affiliation and appointment of one or two of their MHPs—for example, so and so, was a psychotherapist and head of the centre; or so and so, was a psychiatrist and consultant to the centre. With this form of selection, two group listings comprising public, semi-government, voluntary, and private organisations were compiled: one for New Zealand and the other for Singapore.

Thus, the selection of target participants for the two phases of this study was derived from individual professional listings and group listings. The selection of individual MHPs from professional listings and identified individuals from some organisations was straightforward. However, the selection of MHPs in all organisations had to be estimated, and the identification of the individual MHPs was left to the head-in-charge to so do.

Notably, selection of participants for the structured interview was based on respective primary job affiliation ratios (e.g. counsellors, psychologists) of both countries.

Sampling of Participants

Two sampling methods were used for this study. With the available registered professional listings, potential participants were systematically sampled (e.g., every third name on the list) to ensure that correct proportions of MHPs were obtained. With the group listings, sampling of potential participants was by way of estimation (e.g., 3 MHPs in small organisations, and 6 MHPs in larger organisations). If the group listings included identified MHPs, these potential participants were considered for the sampling. Steps were taken to ensure that participants in the two phases were separate.

The final list of target participants consisted of four groups: two groups for the mail questionnaire survey (one group from New Zealand and the other from Singapore), and two groups for the structured interview (one group from New Zealand and the other from Singapore). Details on the selection and sampling of participants from New Zealand and Singapore are given below.

Study 1 (Mail Questionnaire Survey)

New Zealand

Potential participants from New Zealand for the mail questionnaire survey, besides the List of Registered Clinical Psychologists (n = 185), were drawn from the GM Resource and Referral Directory (Culbertson, 2001), Yellow Pages, White Pages, and websites of District Health Boards. These sources displayed or advertised their MHPs either as individuals or subsumed in organisations. For the List of Registered Clinical Psychologists, potential participants were identified systematically (e.g., every third name on the list). For those listed within organisations, an estimation of their

numbers present based on the size of the organisation was used (e.g., 3 MHPs in small companies, and 6 MHPs in larger institutions). For those with identified MHPs, they were specifically addressed for the mail questionnaire survey.

Consequently, two lists of potential participants were extracted: the first consisted of 60 clinical psychologists and 29 psychiatrists identified specifically by job affiliation and name; and the second consisted of an estimation of potential participants from 75 organisations, comprising 17 District Health Boards and 58 semi-government/voluntary/private centres, which advertised counselling or psychotherapy services. The final list derived for distribution of the mail questionnaires to an expected 300 participants. Table 6.1 shows the expected composition of participating MHPs from New Zealand.

Table 6.1
Expected Composition of participating MHPs from New Zealand

Primary Job Affiliation	Known Numbers	Expected Numbers
Counsellor	-	60
Psychiatrist	29	60
Psychologist	60	60
Psychotherapist	5	60
Social Worker	2	60

Singapore

Potential participants from Singapore for the mail questionnaire survey, besides the List of Registered Psychiatrists (obtained from the website of the Singapore Medical Association; n = 79), were drawn from the Directory of Social Services, the Community of Mental Health Professionals (a directory), the Singapore Yellow Pages, and from the websites of the Singapore Psychological Society and the Singapore Association of Social Workers. These sources displayed or advertised their MHPs either as individuals or subsumed in organisations. For the List of Registered Psychiatrists, potential

participants were identified systematically (e.g., every fourth name on the list dropped). For those listed within organisations, an estimation of their numbers present based on the size of the organisation was used (e.g., 3 MHPs in small companies, and 6 MHPs in larger institutions). For those with identified MHPs, they were specifically addressed for the mail questionnaire survey.

Consequently, two lists were extracted: the first consisted of 60 psychiatrists and 12 psychologists identified by job affiliation and name; and the second consisted of an estimation of potential participants from 58 organisations which advertised counselling or psychotherapy services. The final list derived for distribution of the mail questionnaires to an expected 304 participants. Table 6.2 shows the expected composition of participating MHPs from Singapore.

Table 6.2
Expected Composition of participating MHPs from Singapore

Primary Job Affiliation	Known Numbers	Expected Numbers
Counsellor	2	60
Psychiatrist	60	60
Psychologist	12	60
Psychotherapist	-	60
Social Worker	-	60

Study II (Structured Interview)

New Zealand

New Zealand participants for the structured interview were sought from the same sources as those of the mail questionnaire survey. Potential participants, working at various public and private organisations in counselling and psychotherapy, were contacted by letter, email or telephone and asked if they would be willing to participate in the research. Once agreed upon to participate, the participant was informed briefly on

the research objectives, and verbal consent was obtained for the interview to be audiotaped. In all, 12 participants were selected which were representative of the country's demographic ratio and categories of MHPs in the mental health discipline.

Singapore

Singapore potential participants for the structured interview were sought from the same sources as those of the mail questionnaire. Potential participants, working at various public and private organisations in counselling and psychotherapy, were contacted by letter, email or telephone and asked if they would be willing to participate in the research. Once agreed upon to participate, the participant was informed briefly on the research objectives and verbal consent was obtained for the interview to be audiotaped. In all, 12 participants were selected which were representative of the country's demographic ratio and categories of MHPs in the mental health discipline.

Professional, Personal and Practice Characteristics of Participants

Table 6.3 summarises the combined professional, personal and practice characteristics of New Zealand and Singapore participating MHPs in the mail questionnaire survey and structured interview.

Table 6.3
Professional, Personal and Practice Characteristics of New Zealand and Singapore Participants

	New Zealand MHPs (N = 53)	Singapore MHPs (N = 73)
Primary Job Affiliation		
Counsellor	7	22
Psychiatrist	3	13
Psychologist	33	11
Psychotherapist	5	3
Social Worker	3	22
Multiple role	2	2
Gender		
Female	31	51
Male	22	22
Age range		
20-30	3	19
31-40	12	24
41-50	19	24
> 51	19	6
Ethnicity		
Caucasian	45	3
Chinese	4	57
Eurasian	-	1
Filipino	1	-
Indian	1	7
Malay	-	5
Māori	1	-
Pacific Island peoples	1	-
Religious affiliation		
Buddhist	3	5
Christian	16	50
Hindu	-	2
Muslim	-	5
Multiple	3	-
None	19	4
Employment status		
Government	22	21
Private	8	38
Self-employed	8	5
Combination	15	-
Others	-	7
Primary work setting		
In-patient	2	8
Out-patient/Community	25	30
Private practice	14	8
Training	1	2
Combination	9	18
Others	2	5
Focus of practice		
Children	1	4
Adolescents	2	11
Adults	31	16
Geriatrics	1	1
Combination	18	38
Others	-	2

Measures

The two measures used for this study were the mail questionnaire and the structured interview.

Mail Questionnaire

The six-page, double-sided mail questionnaire titled "Comparing Therapist Skills" (see Appendix A) consisted of five sections: Section A on background information of the therapist; Section B on training in counselling and psychotherapy; Section C on information on clientele; Section D on diagnostic system and assessment procedures; and an optional Section E on handling of self-disclosure, religious issues, traditional healers and client's requests. Items in the Sections included forced-choice questions (e.g., "Primary job affiliation"), open-ended questions (e.g., "On what basis do you choose the therapy you most currently use?"), checklist questions (e.g., "To what extent do you use the diagnostic system with the following list of clients?"), and self-report items (e.g., "Other (specify)"). Responses to these questions were made in one of four formats or a combination of them: (1) checking boxes; (2) a 5-point Likert scale, where 1 = most frequent and 5 = least frequent; (3) percentage rating from 0 to 100%; and (4) filling in blank lines or box. Space was also provided for feedback on the mail questionnaire. Most items consisted of a combination of the types of questions and responses mentioned. For example, on item B7, participating MHPs would be asked, "To what extent is your practice guided by the following basics therapy models", and given the 5-point Likert scale to rate their responses while they select from a list of basic therapy models (e.g., Alderain, Behavioural, Cognitive, Eclectic/Integrative, Existential, Experiential, Gestalt, Humanistic, Interpersonal,

Psychoanalytic/Psychodynamic, Rogerian). A blank line was given at the end of the list to allow the participants to fill out their choice of model not listed. Filling out the mail questionnaire would take approximately 20 minutes. An overview of the main sections and items covered in the questionnaire is shown in Table 6.4.

Table 6.4
Items on the Mail Questionnaire for Therapists

Section No.	Section	Topics covered
I	THERAPIST BACK-GROUND	Gender Age Ethnicity Language abilities Religious affiliation Employment status Primary job affiliation Primary work setting Focus of practice On what basis do you choose the therapy you most currently use?
II	THERAPIST TRAINING	Country or countries trained in Qualification(s) in therapy Institution/Organisation qualification(s) obtained from Number of years of supervised training Registration (NZ only) Years of experience in therapy To what extent is your practice guided by the following basic therapy models? To what extent are the basic therapy models relevant to your ethnic clients?
III	CLIENTELE	Estimate percentage of clients seen in past year (2001) Estimate clients' presenting problems in past year (2001)
IV	DIAGNOSTIC SYSTEM	What is your basic diagnostic system? To what extent do you use the diagnostic system with the following list of clients? How often do you use the following diagnostic tools? Estimate percentage of time that you practise the following interventions in therapy. Average number of sessions per client
V	SPECIAL ISSUES (optional)	How do you handle self-disclosure? How do you handle clients who want to involve religious issues in therapy? Therapists sometimes encounter clients who may request the same gender or ethnic group therapist for the therapy sessions: How often have you encountered such requests? Reason(s) for such requests Would you object to a traditional healer working with your client? If no, would you allow a traditional healer to work alongside you in therapy? Any comment on this? How culturally appropriate are therapy practices in your country?

The first aim in designing the mail questionnaire was to develop a standard but brief set of items to obtain characteristics of MHPs. The second aim was to develop additional items that would provide descriptive information useful in the context of therapy practice. For example, important experiential skills for dealing with Asian clientele in New Zealand and Singapore included therapist self-disclosure, religious or spiritual issue, and traditional healing practices. These experiential skills were inserted as "optional special issues" and cross-referenced to issues of therapy preference, client factor, choice of diagnostic system and psychological assessment procedures.

Structured Interview

A 60-minute long, one-on-one, audiotaped structured interview consisted of essential background information of the therapist, and 10 open-ended questions and probes which were used (see Appendix B) to ask participating MHPs about their personal experience on Western therapy and its application to their clientele. The questions included therapist training, efficacy of Westernised counselling or psychotherapy, the presence of indigenous therapy model, views on traditional and modern therapies, profile of clients, diagnostic system and tools, view of religion or spirituality in therapy, and any other comments on the topic (see Table 6.5).

The first aim of the structured interview was to substantiate the information obtained from the mail questionnaire in this mixed-design study. The second aim was to glean additional qualitative information from interviews that would otherwise not be obtainable from questionnaires as discussed earlier.

Table 6.5
Questions in the Structured Interview for Therapists

1. Could you tell me about your training in counselling or psychotherapy? *Which country trained in? Counselling/Psychotherapy/Both* *Length of training (including supervision)* *Qualification or title* *Orientation to therapy?* *Are you registered? (NZ only)* *Years of experience in counselling or psychotherapy* *Focus of therapy (child/adolescent/adults/geriatrics)* *Your preference to therapy?* *The fees you charged per session?*
2. What is your opinion of the efficacy of westernised counselling or psychotherapy? *Efficacy Suitability* *Modification* *Culture-specific*
3. Is there an indigenous counselling or psychotherapy model? *Describe* *Strengths* *Weaknesses* *Applicability*
4. What are your views of traditional therapies like herbal medicine, acupuncture, prayers, etc? *Comparability* *Efficacy Suitability* *Culture-specific*
5. What are your views of "modern therapies" like aromatherapy, massage therapy, meditation, etc? *Comparability* *Efficacy Suitability* *Culture-specific*
6. Could you provide a profile of your clients? *Age Range* *Gender* *Ethnicity* *Types of problems* *Perception and attitude towards therapy* *Beliefs* *Preferences* *Self-disclosure*
7. Do you use a diagnostic system in therapy? *DSM IV/ICD 10* *Others* *Reasons for use*
8. Do you also use diagnostic tools like psychological tests? *Describe* *Frequency* *Reasons for use*
9. What is your view of religion or spirituality in therapy? *Roles of religion in therapy, if any* *Suitability* *In conjunction with religious healers*
10. Other comments (if any)

Note: Prompts to questions are in italics.

Design

A mixed design was used in this study. It comprised a mail questionnaire survey (Study I) followed by a structured interview (Study II) conducted in two phases.

Procedure

For Study I, the sequence of events was: application to Massey University Health and Ethics Committee for approval of this study, conducting a pilot study, launching of the mail questionnaire, despatch of follow-up reminder letter, and coding and analyses of data from returned questionnaires. For Study II, the sequence of events was: the same application for ethics approval as Study I, launching of the structured interviews, transcription of audiotapes, conducting an inter-rater reliability study, and coding and analyses of data.

Materials and Equipment

Equipment for this study included a hand-held audio tape recorder, micro-cassette tapes (one for each interviewee), earphones (to help check quality of recording), and a portable transcriber machine.

Pilot Study

A pilot study for the mail questionnaire was conducted with two groups of people: four psychologists (two each from New Zealand and Singapore) and one Māori lecturer from New Zealand. Endorsement by the latter was in line with respecting the bi-cultural aspects of New Zealand society as mentioned earlier. The Māori lecturer was satisfied that the contents of the questionnaire were culture appropriate.

As a result of the pilot study, successive drafts of the mail questionnaire were made to ensure content validity. Questions were rewritten as needed to improve understandability or to better obtain information the question was designed to address.

For example, "Language spoken" was changed to "Language abilities"; in "Primary work setting", "outpatient" would include community; in "Religious affiliation", Catholic was deleted as Christian was considered the generic term; and the list of "Diagnostic tools" was divided into projective and objective assessment procedures.

Collection of Data

Mail Questionnaire

Two forms of despatch of the mail questionnaire were used. For individual participants, each received a package consisting of an Information Sheet for Clinicians (see Appendix C), the mail questionnaire titled "Comparing Therapist Skills" (See Appendix A), and a prepaid return envelope—for New Zealand participants, freepost stamps were used on the envelopes; for Singapore participants, bought stamps were pasted on the envelopes. The Information Sheet outlined the purpose of the study, assured anonymity of individual responses, and informed that the survey had been reviewed and approved by Massey University Human Ethics Committee.

For participants subsumed in organisations, an additional letter (See Appendix D) was sent to the head-in-charge requesting the forwarding of the packages to the respective participants. For example, a small private therapy centre received 3 copies of the mail questionnaire. A large public health organisation received 6 packages of the mail questionnaire. If an MHP had been identified in the organisation, the mail questionnaire package specifically addressed to the named person. A follow-up reminder letter (see Appendix E) was sent out 4 weeks later urging the return of the questionnaire. However, the practice of sending a second reminder letter 4 weeks after the first was discouraged by the low response rate received after the first reminder.

The mail questionnaires were sent out in New Zealand and Singapore for respective participants but return envelopes were directed to the School of Psychology, Massey University. Administrative staff of Massey University assisted in the despatch of the mail questionnaire in New Zealand. Consent by participants was assumed upon receipt of the completed questionnaire. An identification code was assigned to each returned mail questionnaire for ease of data processing.

Response Rates

Response rates to the mail questionnaire were 20% from New Zealand MHPs consisting of 18 males and 23 females (N = 41), and 27% from Singapore MHPs consisting of 16 males and 45 females (N = 61). All returned mail questionnaires were usable for analysis. Reasons for non-participation by New Zealand and Singapore MHPs in the mail questionnaire are summarised in Table 6.6.

Table 6.6
Reasons for Non-participation by New Zealand and Singapore Mental Health Practitioners (mail questionnaire)

New Zealand MHPs (n = 19)[a]	Singapore MHPs (n = 20)[a]
Not able or in position to participate	Not participating
Not in department's policy to participate	Function of organisation not suitable
No time for study	Not having time to do
No counsellor present	Not suitable candidates
Person resigned or deceased	Does not fulfil criteria
Closing down business	Not sure
Little clinical practice or not seeing clients nowadays	Staff not professional counsellors or psychotherapists
	Unable to assist in distributing questionnaires or gathering information

Note. [a]Responses include returned uncompleted questionnaires without reason(s) given.

These reasons were written on the reply envelopes or in personal emails to the principal researcher. Apart from these responses, New Zealand and Singapore MHPs had provided important feedback through emails or written comments on the

questionnaire. Some had requested a copy of the findings from the study. They were emailed the paper on the preliminary findings of the study, which was presented and published in the proceedings of The Inaugural Asian Health Conference held at the University of Auckland in November 2004 (Foo & Merrick, 2004).[6] In spite of telephone and email contacts, and remind letters, the return rates remained relatively low. Only four questionnaires were received each for both countries after the remind letters.

Structured Interview

The structured interviews were conducted by the principal researcher personally and held at the office or clinic of the participants in New Zealand and Singapore respectively. Prior to the start of the interview, an Information Sheet for Clinicians (Interview) (see Appendix F) and a Consent Form (see Appendix G) for acknowledgement and audio taping were given out to the participant. As well, the interview questions were shown briefly to the participants for a quick preview. During the interview, the principal researcher asked the questions and prompted the participant with probes (see words and phrases in italics in Table 6.5). As well, brief notes were taken simultaneously to augment the audio recording. At the end of the interview, the practitioners were thanked for their participation in the study and were asked for feedback on the interview.

An identification code was assigned to each participant in the structured interview group to provide for anonymity.

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[6] See No. 1 of Appendix U.

Inter-rater Reliability Study

Statements obtained from participants from open-ended questions in both Studies I and II were complied and tabled for evaluation by 4 assessors. Items required the assessors to first answer yes/no to whether the statement given by each participant fit the theme, and then to rate the response on a 5-point Likert scale, from 1 (least related to theme) to 5 (most related to theme). They were also required to provide feedback on the study.

Four independent staff members of the Psychology Department were recruited as assessors in the study. They were two clinical psychologists and two administrative staff. All returns were made within the stipulated 2-week period. A sample of the study is shown on Appendix H.

Coding and Analyses of Data

Quantitative data collected in this study were coded and analysed using the SPSS for Windows, release 11.0 (Norusis, 2002), on a personal computer. Descriptive analyses and limited non-parametric inferential statistical tests were performed on all forced-choice data. Interview data were transcribed verbatim, proofread by the principal researcher, and coded accordingly. Content and thematic analyses (as recommended by Neuendorf, 2002) were conducted on qualitative data. The analyses focussed on identifying similarities and differences among participants in terms of their experience in therapy practices. For example, the bases in which the MHPs had chosen for their choice of therapy models currently in use. As well, the analyses investigated specific episodes. Episodes were the positive and negative experiences or occurrences that were of importance in therapy learning to the participants. Analyses of episodes provided an

opportunity to understand how these unusual experiences or occurrences might have influenced later interactions between MHPs and their clients.

Noted was that both quantitative and qualitative data were made available in both Studies I and II. The mail questionnaire comprised 60% force-choice questions (including checklist questions akin to force-choice questions) and 40% open-ended questions (including self-report questions akin to open-ended questions). Similarly, the structured interview contained mainly open-ended questions, and personal and professional information (akin to forced-choice questions) of the participants.

Ethics

Massey University Health and Ethics Committee received and approved the study. All participants were informed that their participation was voluntary and anonymous; and questions were related to their personal opinions on counselling or psychotherapy. An identification code was assigned to each returned mail questionnaire and each participant in the structured interviews to provide for anonymity. It was ensured that the participants for the structured interview were not sent the mail questionnaire.

Summary

The present study consisted of two parts. Study I was a mail questionnaire survey conducted on New Zealand and Singapore MHPs, 300 each, which resulted in response rate of 20% (N = 41) and 27% (N = 61) respectively. Study II was a structured interview with 12 MHPs each from both these countries with a response rate of 100% each (N = 12).

CHAPTER 7

RESULTS

This chapter presents findings of the study in three parts. Part I presents results of from mail questionnaire according to the personal, professional and practice characteristics of the participating New Zealand and Singapore MHPs, with emphasis on quantitative data and some qualitative data. Part II presents results from the structured interview also according to the personal, professional and practice characteristics of the participating MHPs, but with emphasis on qualitative data. Part III presents the combined results from Parts I and II, constituting the main findings of the study, in the order of the research hypotheses.

Straightforward item-by-item comparisons are performed for Parts I and II. Detailed analyses are undertaken only with the combined results in Part III, as a logical step since both quantitative and qualitative data were present in Studies I and II. It also shows the strength of the mixed design (Todd, Nerlich, & McKeown, 2004).

Statistical Analysis

Descriptive analyses (frequencies and percentages) were generated from the quantitative data collected in the study. Limited non-parametric inferential statistical tests were performed on the quantitative data because of the diversity of the participating MHPs in the samples from both countries and the relatively small sample sizes.

Content Analysis

Contents were analysed and themes were identified from the qualitative data collected in this study using methods described by Neuendorf (2002). In a nutshell, the verbatim transcriptions from the audio tapes were categorised by similar words or phrases or sentences, and superfluous words were discarded. Themes were identified from the categories.

Inter-rater Reliability

Interrater reliabilities were calculated with single-measure intraclass correlations,[7] with raters as a random effect, type as absolute agreement, and the measure as a random effect, except that kappa was used for the variable. The reliabilities correlations were moderate across the four assessor-rated items ($r_4 = .61$). Based on the ratings of Barrett (2001), this value was considered a conservative good value for intraclass r_k calculated for inter-rater reliability. However, a high value (95%) was obtained for simple percentages calculated for inter-rater reliability. The difference in values between these measures is due to the conservative nature of the intraclass r_k and its better assessment quality.

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[7] Note that the intraclass r_k was preferred to the interclass r_k because the former takes into account variance between raters whereas the latter only accounts for differences between raters (Barrett, 2001).

PART I: RESULTS FROM MAIL QUESTIONNAIRE

Part I presents results of from mail questionnaire according to the personal, professional and practice characteristics of the participating New Zealand and Singapore MHPs, with emphasis on quantitative data and some qualitative data. Personal characteristics include demographic characteristics. Professional and practice characteristics of MHPs, for ease of presentation, are sub-divided. Professional characteristics are sub-divided into two categories: training; and primary job affiliation, use of Western therapy models and interventions. Practice characteristics are sub-divided into five categories: practice setting; diagnostic system and assessment procedures; client and caseload; gender/ethnic match; and experiential skills.

Personal and Demographic Characteristics of MHPs

Data collected from the mail questionnaire on personal and demographic characteristics of MHPs with respect to gender, age range, ethnicity, language ability, and religious affiliation are shown in Table 7.1. Relevant comparisons are highlighted in the item-by-item analyses.

Gender

For both countries, the numbers of responses from female MHPs (New Zealand, 56%; Singapore, 74%) were higher than those from male MHPs (New Zealand, 44%; Singapore, 26%).

Table 7.1
Personal and Demographic Characteristics of New Zealand and Singapore Mental Health Practitioners (mail questionnaire)

	New Zealand MHPs (N = 41)	Singapore MHPs (N = 61)
Gender		
Female	23 (56.1%)	45 (73.8%)
Male	18 (43.9%)	16 (26.2%)
Age range		
20-30	1 (2.4%)	18 (29.5%)
31-40	8 (19.5%)	20 (32.8%)
41-50	16 (39.0%)	17 (27.9%)
> 51	16 (39.0%)	6 (9.8%)
Ethnicity		
Caucasian	39 (95.1%)	3 (4.9%)
Chinese	-	48 (78.7%)
Eurasian	-	1 (1.6%)
Filipino	1 (2.4%)	-
Indian	1 (2.4%)	6 (9.8%)
Malay	-	3 (4.9%)
Language ability		
Chinese	-	1 (1.6%)
English	27 (65.9%)	7 (11.5%)
Malay	-	1 (1.6%)
Tagalog	1 (2.4%)	-
English and other languages	12 (29.3%)	52 (85.2%)
Undisclosed	1 (2.4%)	-
Religious affiliation		
Buddhist	3 (7.3%)	5 (8.2%)
Christian	13 (31.7%)	46 (75.4%)
Hindu	-	3 (4.9%)
Muslim	-	2 (3.3%)
Agnostic	1 (2.4%)	-
Eclectic	2 (4.9%)	-
None	19 (46.3%)	4 (6.6%)
Undisclosed	3 (7.3%)	1 (1.6%)

Note. All percentages are rounded off to one decimal place; hence the total percentage in each column may not be 100.

Age range

With data collapsed into two categories (i.e., below 40, and over 41 years of age), 22% of New Zealand MHPs compared with 62% of Singapore MHPs were in the age group below 40 years, whereas 78% of New Zealand MHPs compared with 38% of Singapore MHPs were in the age group over 41 years.

Ethnicity

On ethnicity, 95% of New Zealand MHPs compared with 5% of Singapore MHPs indicated they were Caucasian, whereas none from New Zealand MHPs compared with 79% of Singapore MHPs indicated they were Chinese. Both samples of participating MHPs, however, are representative of the general ethnic ratio in their own country (Statistics New Zealand, 2006; Statistics Singapore 2006).

Language ability

On language ability, 66% of New Zealand MHPs compared with 12% of Singapore MHPs indicated that English was their main language ability, whereas 29% of New Zealand MHPs compared with 85% of Singapore MHPs indicated that English and at least one other language were their main language ability. Generally, English is the medium used in therapy sessions by MHPs of both countries.

Religious affiliation

On religious affiliation, 32% of New Zealand MHPs compared with 75% of Singapore MHPs indicated Christianity. New Zealand's sample of participating MHPs is not representative of its normal population, which is predominantly Christian (over 50%; Statistics New Zealand, 2006). Singapore's sample of participating MHPs is also not representative of its population ratio, which is predominantly Chinese who are mainly Buddhists or Taoists (64%; Statistics Singapore, 2006).

Thus, similarities in personal and demographic characteristics between MHPs of both countries were found in terms of gender, ethnicity and language ability. Differences between them were found in terms of age range and religious affiliation.

Professional Characteristics (Training) of MHPs

Data collected from the mail questionnaire on professional training characteristics of MHPs with respect to country of therapy training, qualification in therapy, number of years of supervised training received, registration of practice, and years of experience in therapy are shown in Table 7.2. Relevant comparisons are highlighted in the item-by-item analyses.

Country of therapy training

On country of therapy training, 61% of New Zealand MHPs compared with 39% of Singapore MHPs were trained in their own country. Many MHPs had their therapy training done in more than one country (New Zealand 32%; Singapore 38%).

Qualification in therapy

On qualification in therapy, none from New Zealand MHPs compared with 16% of Singapore MHPs held a bachelor's degree, 20% of New Zealand MHPs compared with 26% of Singapore MHPs held a masters degree, and 34% of New Zealand MHPs compared with 5% of Singapore MHPs held a post-graduate diploma. All percentages would increase if multiple qualifications were considered, but exact numbers were indeterminable due to a lack of specificity.

Years of supervised training received

In general, MHPs of both countries had about two to three years of supervision in their therapy training (New Zealand, 37%; Singapore, 46%). Twenty-four percent of New Zealand MHPs chose not to respond to this item compared with 7% from Singapore MHPs who did not do so.

Table 7.2
Professional Characteristics (Training) of New Zealand and Singapore Mental Health Practitioners (mail questionnaire)

	New Zealand MHPs (N = 41)	Singapore MHPs (N = 61)
Country of therapy training		
Australia	-	4 (9.8%)
Canada	-	1 (1.6%)
India	-	1 (1.6%)
New Zealand	25 (61.0%)	-
Singapore	-	24 (39.3%)
South Africa	1 (2.4%)	-
United Kingdom	2 (4.9%)	2 (6.6%)
USA	-	6 (9.8%)
More than one country	13 (31.7%)	23 (37.7%)
Qualification in therapy		
Certificate	-	3 (4.9%)
Diploma	2 (4.9%)	3 (4.9%)
Bachelor's Degree	-	10 (16.4%)
Masters Degree	8 (19.5%)	16 (26.2%)
Doctorate Degree	1 (2.4%)	1 (1.6%)
Post-graduate Diploma	14 (34.1%)	3 (4.9%)
Graduate Diploma	1 (2.4%)	-
Multiple[a]	15 (36.6%)	22 (36.1%)
Others	-	2 (3.3%)
Undisclosed	-	1 (1.6%)
Number of years of supervised training received		
One year	2 (4.9%)	6 (9.8%)
One and one half years	-	1 (1.6%)
Two	5 (12.2%)	17 (27.9%)
Three	10 (24.4%)	11 (18.0%)
Four	7 (17.1%)	8 (13.1%)
Four and a half years	-	1 (1.6%)
Five	4 (9.8%)	5 (8.2%)
Six and over	3 (7.3%)	8 (13.1%)
Undisclosed	10 (24.4%)	4 (6.6%)
Registration of practice		
Yes	38 (92.7%)	11 (18.0%)[b]
Not appropriate	2 (4.9%)	-
Undisclosed	1 (2.4%)	-
Years of experience in therapy		
1-10	12 (29.3%)	44 (72.1%)
11-20	15 (36.6%)	10 (16.4%)
21-30	13 (31.7%)	6 (9.8%)
>30	1 (2.4%)	1 (1.6%)

Note. All percentages are rounded off to one decimal place; hence the total percentage in each column may not be 100.
[a]Multiple qualifications did not indicate specific qualification in therapy. [b]Only psychiatrists are required to register their practice in Singapore.

Registration of practice

On registration of practice, 93% of New Zealand MHPs were registered for practice with their respective professional body, for example, the New Zealand Association of Counsellors; the rest who were not registered were awaiting approval or were registered with a non-therapy body. All Singapore MHPs registered for practice were psychiatrists (18%)—in Singapore, only medically trained professionals are required to register their practice.

Years of experience in therapy

With data collapsed into three categories (i.e., 10 years or less, 11 to 20 years, and over 21 years of experience), 29% of New Zealand MHPs compared with 72% of Singapore MHPs had less than 10 years of experience in therapy, 37% of New Zealand MHPs compared with 16% of Singapore MHPs had between 11 and 20 years of experience in therapy, whereas 34% of New Zealand MHPs compared with 11% of Singapore MHPs had over 21 years of experience in therapy.

Thus, similarities in professional training characteristics between MHPs of both countries were found in terms of years of qualification in therapy, and supervised training received. Differences between them were found in terms of country of therapy training, registration of practice, years of experience in therapy.

Professional Characteristics (Primary Job Affiliation and Use of Western Therapy Models and Interventions) of MHPs

Data collected from the mail questionnaire on professional characteristics of MHPs concerning primary job affiliation, and use of Western therapy models and

interventions are shown in Table 7.3. Relevant comparisons are highlighted in the item-by-item analyses.

Table 7.3
Professional Characteristics (Primary Job Affiliation and Use of Western Therapy Models and Interventions) of New Zealand and Singapore Mental Health Practitioners (mail questionnaire)

	New Zealand MHPs (N = 41)	Singapore MHPs (N = 61)
Primary Job Affiliation		
Counsellor	2 (4.9%)	19 (31.1%)
Psychiatrist	2 (4.9%)	11 (18.0%)
Psychologist	29 (70.7%)	8 (13.1%)
Psychotherapist	4 (9.8%)	2 (3.3%)
Social Worker	2 (4.9%)	19 (31.1%)
Multiple role	2 (4.9%)	2 (3.3%)
Western therapy models used ≥50% of total time in practice[a, b]		
Behaviour model	31 (75.6%)	43 (70.5%)
Cognitive model	37 (90.2%)	45 (73.8%)
Eclectic/Integrative model	27 (65.9%)	35 (57.4%)
Humanistic model	18 (44.0%)	22 (36.1%)
Interpersonal model	23 (56.1%)	27 (44.3%)
Psychoanalytic/Psychodynamic model	16 (39.0%)	17 (27.9%)
Rogerian model	18 (44.0%)	27 (44.3%)
Frequency of use of therapy interventions ≤30% of time in practice[a, b]		
Behavioural management	22 (53.7%)	26 (42.6%)
Brief therapy	15 (36.6%)	20 (32.8%)
Cognitive therapy	18 (43.9%)	20 (32.8%)
Cognitive-behavioural therapy	14 (34.1%)	24 (39.3%)
Family therapy	15 (36.6%)	25 (41.0%)
Marital therapy	22 (53.7%)	25 (41.0%)
Psychoeducation	18 (43.9%)	17 (27.9%)
Relaxation	21 (51.2%)	19 (31.1%)
Stress management	13 (31.7%)	24 (39.3%)

Note. All percentages are rounded off to one decimal place; hence the total percentage in each column may not be 100.
[a]Participants were asked to indicate frequency of use between 0-100% of time. Only frequencies of significance are tabled here. [b]Multiple endorsements are allowed; hence total percentage of column may add up to more than 100.

Primary job affiliation

On primary job affiliation for both countries, comparative differences were seen in three categories of MHPs: 5% of New Zealand MHPs compared with 31% of Singapore MHPs were counsellors; 71% of New Zealand MHPs compared with 13% of

Singapore MHPs were psychologists; and 5% of New Zealand MHPs compared with 31% of Singapore MHPs were social workers.

Use of Western therapy models

Three Western therapy models identified by MHPs of both countries that were used at least 50% of total practice time in 2001 were: the behaviour model (New Zealand, 76%; Singapore, 71%), the cognitive model (New Zealand, 90%; Singapore, 74%), and the eclectic/integrative model (New Zealand, 66%; Singapore, 57%).

Use of Western therapy interventions

Six Western therapy interventions identified by MHPs from both countries that were used no more than 30% of practice time were: behaviour management (New Zealand, 54%; Singapore, 43%), cognitive therapy (New Zealand, 44%; Singapore, 33%), cognitive behaviour therapy (New Zealand, 34%; Singapore, 39%), marital therapy (New Zealand, 54%; Singapore, 41%), psychoeducation (New Zealand 44%; Singapore, 28%) and relaxation (New Zealand, 51%; Singapore, 31%).

Thus, similarities in professional characteristics between MHPs of both countries were found in terms of use of Western therapy models and interventions. Differences between them were found in terms of primary job affiliation.

Practice Characteristics (Practice Setting) of MHPs

Data collected from the mail questionnaire on practice characteristics (practice setting) of MHPs with respect to employment status, primary work setting, and focus of

practice are shown in Table 7.4. Relevant comparisons are highlighted in the item-by-item analyses.

Employment status

On employment status, 32% of New Zealand MHPs and 30% of Singapore MHPs were working in the public sector, 37% of New Zealand MHPs compared with 62% of Singapore MHPs were in private practice (inclusive of self-employment), whereas 32% of New Zealand MHPs compared with none from Singapore MHPs were in private practice or self-employed and simultaneously working in a government setting.

Table 7.4
Practice Characteristics (Practice Setting) of New Zealand and Singapore Mental Health Practitioners (mail questionnaire)

	New Zealand MHPs (N = 41)	Singapore MHPs (N = 61)
Employment status		
Government	13 (31.7%)	18 (29.5%)
Private	7 (17.1%)	33 (54.1%)
Self-employed	8 (19.5%)	5 (8.2%)
Combination of above	13 (31.7%)	-
Others	-	3 (4.9%)
Undisclosed	-	2 (3.3%)
Primary work setting		
In-patient	2 (4.9%)	6 (9.8%)
Out-patient/Community	15 (36.6%)	24 (39.3%)
Private practice	14 (34.1%)	8 (13.1%)
Training	1 (2.4%)	2 (3.3%)
Combination of above	7 (17.1%)	14 (23.0%)
Others	2 (4.9%)	5 (8.2%)
Undisclosed	-	2 (3.3%)
Focus of practice		
Children	1 (2.4%)	4 (6.6%)
Adolescents	-	10 (16.4%)
Adults	29 (70.7%)	16 (26.2%)
Geriatrics	-	1 (1.6%)
Couples/Family	-	2 (3.3%)
Combination of above	11 (26.8%)	27 (44.3%)
Undisclosed	-	1 (1.6%)

Note. All percentages are rounded off to one decimal place; hence the total percentage in each column may not be 100.

Primary work setting

On primary work setting, 37% of New Zealand MHPs and 39% of Singapore MHPs were working in outpatient or community care, whereas 34% of New Zealand compared with 13% of Singapore MHPs were in private practice. A discrepancy between the data on private (in "Employment status") and private practice (in "Primary work setting") indicated by MHPs of both countries occurred because of the possible combinations of the items indicated—for example, "Self-employed" was ticked with "Private practice"; "Private" was ticked with "Outpatient/community" but not with "Private practice".

Focus of practice

On focus of practice, 71% of New Zealand MHPs compared with 26% of Singapore MHPs indicated they were providing therapy services mainly for adult clients, and 27% of New Zealand MHPs compared with 44% of Singapore MHPs indicated they were providing therapy services across all client groups.

Thus, there was no similarity in practice characteristics between MHPs of both countries. Differences between them were found in terms of employment status and primary work setting. Data on focus of practice was inconclusive.

Practice Characteristics (Diagnostic System and Assessment Procedures) of MHPs

Data collected from the mail questionnaire on practice characteristics of MHPs concerning diagnostic system and use of assessment procedures are shown in Table 7.5. Relevant comparisons are highlighted in the item-by-item analyses.

Table 7.5
Practice Characteristics (Diagnostic System and Assessment Procedures) of New Zealand and Singapore Mental Health Practitioners (mail questionnaire)

	New Zealand MHPs (N = 41)	Singapore MHPs (N = 61)
Diagnostic system used in practice		
Use of DSM IV	34 (82.9%)	30 (49.2%)
Use of ICD 10	-	6 (9.8%)
Others	1 (2.4%)	4 (6.6%)
Multiple	3 (7.3%)	1 (1.6%)
Undisclosed	3 (7.3%)	20 (32.8%)
Frequency of use of assessment procedures ≥50% of time in practice[a, b]		
Wechsler Scales	20 (48.8%)	15 (24.6%)
Depression/Anxiety Scales	29 (70.7%)	19 (31.1%)

Note. All percentages are rounded off to one decimal place; hence the total percentage in each column may not be 100.
[a]Participants were asked to indicate frequency of use between 0-100% of time. Only frequencies of significance are tabled here. [b]Multiple endorsements are allowed; hence total percentage of column may add up to more than 100.

Diagnostic system

On diagnostic system, 83% of New Zealand MHPs compared with 49% of Singapore MHPs had used mainly the DSM IV. The lower percentage obtained for the Singapore sample was partly due to the fact that 33% did not indicate their views on it compared with 7% from New Zealand MHPs who did not do so.

Use of assessment procedures

Two assessment procedures identified by MHPs from both countries that were used at least 50% of practice time were: the Wechsler Scales (New Zealand, 49%; Singapore, 25%) and the depression/anxiety scales (e.g. Beck's Inventories; New Zealand, 71%; Singapore, 31%).

Thus, similarities in practice characteristics between MHPs of both countries were found in terms of diagnostic system and use of assessment procedures. No differences between them were found.

Practice Characteristics (Client and Caseload) of MHPs

Data collected from the mail questionnaire on practice characteristics (client and caseload) of MHPs with respect to clients seen, clients' presenting problems, and average number of sessions per client are shown in Table 7.6. Relevant comparisons are highlighted in the item-by-item analyses.

Clients seen

In 2001, the clients seen by MHPs of both countries were different ethnically and in numbers, but not representative of their population ratio. Mainly Caucasian clients were seen by 98% of New Zealand MHPs, fewer Māori clients by 90% of them, and fewer Pacific Island peoples' clients by 39% of them. Mainly Chinese clients were seen by 84% of Singapore MHPs, fewer Indian clients by 84% of them, and fewer Malay clients by 72% of them. For New Zealand, over-representation was seen among Māori and Pacific Island peoples, whereas for Singapore, over-representation was seen among Indians and Malays.

Clients' presenting problems

The most frequently presented problems identified by MHPs of both countries (in at least 50% of practice time) were anxiety, behaviour problems (e.g. school refusal, conduct problem), generalised anxiety disorder, major depression and marital problems. Next frequently presented problems (in at least 30% of practice time) were alcohol abuse, attention deficit disorder, eating disorder, personality problems, schizophrenia, and substance abuse. The least frequently presented problems (in at least 20% of practice time) were bipolar disorder, obsessive-compulsive disorder, panic disorder and phobia. However, there were clients' problems reported unilaterally occurring in one

Table 7.6
Practice Characteristics (Client and Caseload) of New Zealand and Singapore Mental Health Practitioners (mail questionnaire)

		New Zealand MHPs (N = 41)	Singapore MHPs (N = 61)
Frequency of clients seen in total practice time in 2001[a, b] (with % of time in [])			
Caucasian	[≤ 30%]	-	20 (32.8%)
	[≥ 40%]	40 (97.6%)	2 (3.3%)
Chinese	[≤ 30%]	15 (36.6%)	5 (8.2%)
	[≥ 40%]	-	51 (83.6%)
Indians	[≤ 30%]	11 (26.8%)	48 (83.6%)
Japanese	[≤ 10%]	4 (6.6%)	6 (9.8%)
Koreans	[≤ 10%]	2 (4.9%)	2 (3.3%)
Malays	[≤ 50%]	1 (2.4%)	44 (72.1%)
Māori	[≤ 50%]	37 (90.2%)	1 (1.6%)
Pacific Island peoples	[≤ 30%]	24 (39.3%)	4 (6.6%)
Clients' presenting problems seen in practice ≤50% of time[a, b]			
Anxiety		24 (58.5%)	31 (50.8%)
Behavioural problems		18 (43.9%)	32 (52.5%)
Generalised Anxiety Disorder		17 (41.5%)	20 (32.8%)
Major Depression		24 (58.5%)	30 (49.2%)
Marital problems		25 (61.0%)	32 (52.5%)
Clients' presenting problems seen in practice ≤30% of time[a, b]			
Alcohol Abuse		17 (41.5%)	21 (34.4%)
Attention Deficit Disorder		15 (36.7%)	20 (32.8%)
Eating disorder		22 (53.7%)	14 (23.0%)
Personality Problems		20 (48.8%)	24 (39.3%)
Schizophrenia		10 (24.4%)	14 (23.0%)
Substance Abuse		15 (36.7%)	17 (27.9%)
Clients' presenting problems seen in practice ≤20% of time[a, b]			
Bipolar Disorder		19 (46.3%)	11 (18.0%)
Obsessive-compulsive Disorder		20 (48.8%)	17 (27.9%)
Panic Disorder		20 (48.8%)	12 (19.7%)
Phobia		17 (41.5%)	12 (19.7%)
Clients' problems outlined by 1 country only			
Financial problems		-	3 (4.9%)
Parenting issues		-	3 (4.9%)
Sexual abuse and related PTSD		11 (26.8%)	-
Average number of sessions per client			
≤ 5		10 (24.4%)	22 (36.1%)
6-10		11 (26.8%)	23 (37.7%)
≥ 11		17 (41.5%)	7 (11.5%)
Undisclosed		3 (7.3%)	9 (14.8%)

Note. All percentages are rounded off to one decimal place; hence the total percentage in each column may not be 100.
[a]Participants were asked to indicate frequency of use between 0-100% of time. Only frequencies of significance are tabled here. [b]Multiple endorsements are allowed; hence total percentage of column may add up to more than 100.

country only. Reported only by New Zealand MHPs (27%) were sexual abuse and related post-traumatic stress disorder, whereas reported only by Singapore MHPs (5% each) were financial problems and parenting issues.

Average number of sessions per client

With data collapsed into two categories (i.e., 10 sessions or less, and 11 sessions or more), 51% of New Zealand MHPs compared with 74% of Singapore MHPs had an average of 10 sessions or less per client, whereas 42% of New Zealand MHPs compared with 12% of Singapore MHPs had an average of 11 sessions or more per client. In other words, New Zealand MHPs had more therapy sessions with their clients than Singapore MHPs had with theirs. Fifteen percent of Singapore MHPs chose not to respond to this item compared with 7% from New Zealand MHPs who did not do so.

Thus, similarities in practice characteristics between MHPs of both countries were found in clients seen and clients' presenting problems. Differences between them were found in terms of average number of sessions per client.

Practice Characteristics (Gender/Ethnic Match) of MHPs

Data collected from the mail questionnaire on practice characteristics of MHPs concerning gender/ethnic match are shown in Table 7.7. Relevant comparisons are highlighted in the item-by-item analyses.

Clients' request and reasons for same gender/ethnic therapist

Clients' request for the same gender or ethnic therapist was rated moderate to low (considering mostly to 50/50) by MHPs from both countries (New Zealand, 46%;

Singapore, 28%) to occur at least 50% of total practice time in 2001. The three main reasons cited by clients for their requests were: cultural or language issues (New Zealand, 12%; Singapore, 13%), personal preference (New Zealand, 22%; Singapore, 12%), and problem-based (New Zealand, 27%; Singapore, 12%). Thirty-nine percent of Singapore MHPs did not indicate client's reasons for their requests compared with 7% from New Zealand MHPs who did not do so.

Table 7.7
Practice Characteristics (Gender/Ethnic Match) of New Zealand and Singapore Mental Health Practitioners (mail questionnaire)

	New Zealand MHPs (N = 41)	Singapore MHPs (N = 61)
Clients' frequency (in total practice time) of request for same gender/ethnic therapist		
Mostly	2 (4.9%)	1 (1.6%)
More than half	4 (9.8%)	4 (6.6%)
50/50	13 (31.7%)	12 (19.7%)
Less than half	12 (29.3%)	20 (32.8%)
Not at all	7 (17.1%)	18 (29.5%)
Undisclosed	3 (7.3%)	6 (9.8%)
Clients' reasons for requests above		
Cultural/Language issues	5 (12.2%)	8 (13.1%)
Personal preference	9 (22.0%)	7 (11.5%)
Comfort/Safety	4 (6.6%)	6 (9.8%)
Problem-based	11 (26.8%)	7 (11.5%)
Organisation	1 (2.4%)	1 (1.6%)
Other concerns	4 (6.6%)	2 (3.3%)
Combination of above	4 (6.6%)	6 (9.8%)
Undisclosed	3 (7.3%)	24 (39.3%)

Note. All percentages are rounded off to one decimal place; hence the total percentage in each column may not be 100.

Thus, similarities in practice characteristics between MHPs of both countries were found in gender/ethnic match. No differences between them were found.

Practice Characteristics (Experiential Skills) of MHPs

Data collected from the mail questionnaire on practice characteristics (experiential skills) of MHPs with respect to preference for Western therapy models, relevance of Western therapy models to population, and therapists' handling of self-disclosure, religious or spiritual issues, and traditional healers are shown in Table 7.8. Relevant comparisons are highlighted in the item-by-item analyses.

Table 7.8
Practice Characteristics (Experiential Skills) of New Zealand and Singapore Mental Health Practitioners (mail questionnaire)

	New Zealand MHPs (N = 41)	Singapore MHPs (N= 61)
Western therapy model preference based on		
Empirical evidence/training	19 (46.3%)	9 (14.8%)
Practitioner's personal preference	5 (12.2%)	11 (18.0%)
Client's personal preference	7 (17.1%)	12 (19.7%)
Organisation's practice	-	1 (1.6%)
Combination of above	7 (17.1%)	11 (18.0%)
Other concerns	1 (2.4%)	4 (6.6%)
Undisclosed	2 (4.9%)	13 (21.3%)
Western therapy models are ≥50%[a] relevant to population, but modified for use with non-Caucasian ethnic groups	31 (75.6%)[c]	42 (68.9%)[c]
Therapist's self-disclosure		
Agreeable with some in session	29 (70.7%)	33 (54.1%)
Not agreeable	2 (4.9%)	2 (3.3%)
Other concerns	2 (4.9%)	1 (1.6%)
Undisclosed	8 (19.5%)	25 (41.0%)
Religious/Spiritual Issues		
Agreeable to discuss and refer on	32 (78.0%)	39 (63.9%)
Not agreeable	-	2 (3.3%)
Other concerns	3 (7.3%)	5 (8.2%)
Undisclosed	6 (14.6%)	15 (24.6%)
Traditional healers		
No objection to services	35 (85.4%)	46 (75.4%)
Objection to services	3 (7.3%)	7 (11.5%)
Undisclosed	3 (7.3%)	8 (13.1%)
Allowing them alongside in therapy[b]	24 (58.5%)	15 (24.5%)
Not allowing	9 (22.0%)	27 (44.3%)
Undisclosed	8 (19.5%)	19 (31.1%)

Note. All percentages are rounded off to one decimal place; hence the total percentage in each column may not be 100.
[a]Participants were asked to indicate frequency of use between 0-100% of time. Only frequencies of significance are tabled here. [b]Based on the responses of "no objection to services" to traditional healers. [c]Figures represent the average for the 3 main ethnic groups in New Zealand (Caucasian, Māori and Pacific Island peoples) and Singapore (Chinese, Malay and Indian) respectively.

Preference for Western therapy models

On preference for Western therapy models, 46% of New Zealand MHPs compared with 15% of Singapore MHPs indicated that their preference were based on empirical evidence and professional training, whereas 12% of New Zealand MHPs compared with 18% of Singapore MHPs indicated that their preference were based on own preferences rather than those of the clients. Five percent of New Zealand MHPs did not indicate their reasons for preference of Western therapy models compared with 21% of Singapore MHPs who did not do so.

Relevance of Western therapy models to population

In general, Western therapy models were rated high by MHPs from both countries (New Zealand, 76%; Singapore, 69%) to be at least 50% relevant to their own population but modified for use with non-Caucasian ethnic groups.

Therapists' handling of self-disclosure, religious or spiritual issues, and traditional healers

MHPs from both countries generally agreed that some or minimal self-disclosure in session was beneficial for the therapeutic relationship (New Zealand, 71%; Singapore, 54%). They also agreed to discuss clients' religious or spiritual issues in session and refer on to a person of religious qualification to handle the case if necessary (New Zealand, 78%; Singapore, 64%). Furthermore, they had no objection to the use of traditional healing services by clients (New Zealand, 85%; Singapore, 75%). On the topic of traditional healers, many MHPs (New Zealand, 59%; Singapore, 25%) would allow them to work alongside the therapist in session. Interestingly, given the nature of Singaporeans, a higher percentage of Singapore MHPs did not indicate their views on these three issues compared with that from New Zealand MHPs who did not do so—therapist's self disclosure (New Zealand, 20%; Singapore 41%); religious/spiritual

issues (New Zealand 15%; Singapore 25%); use of traditional healing services (New Zealand, 7%; Singapore 13%); and allowing the traditional healer alongside therapy (New Zealand, 20%; Singapore 31%).

Thus, similarities in practice characteristics between MHPs of both countries were found in their estimation of relevance of Western therapy models to population, and therapists' handling of self-disclosure, religious or spiritual issues, and traditional healers. Differences between them were found in their preference for Western therapy models.

PART II: RESULTS FROM STRUCTURED INTERVIEW

For this part of the study, 12 MHPs each from New Zealand (N = 12; 4 males and 8 females) and Singapore (N = 12; 6 males and 6 females) were interviewed. Part II presents results from the structured interview also according to the personal, professional and practice characteristics of the participating MHPs, but with emphasis on qualitative data. Personal characteristics include demographic characteristics. Professional and practice characteristics of MHPs, for ease of presentation, are sub-divided. Professional characteristics are sub-divided into two categories: training; and primary job affiliation, use for Western therapy models and interventions. Practice characteristics are sub-divided into four categories: practice setting; diagnostic system and assessment procedures; client and caseload; and experiential skills.

Personal and Demographic Characteristics of MHPs

Data collected from the structured interview on personal and demographic characteristics of MHPs with respect to gender, age range, ethnicity, language ability, and religious affiliation are shown in Table 7.9. Relevant comparisons are highlighted in the item-by-item analyses.

Gender

For New Zealand, the number of participating female MHPs was higher than that of the number of participating male MHPs (female, 67%; male, 33%), whereas the number of participating MHPs from Singapore was equal for both genders (female, 50%; male 50%).

Table 7.9
Personal and Demographic Characteristics of New Zealand and Singapore Mental Health Practitioners (structured interview)

	New Zealand MHPs (N = 12)	Singapore MHPs (N = 12)
Gender		
Female	8 (66.7%)	6 (50.0%)
Male	4 (33.3%)	6 (50.0%)
Age range		
20 to 30	2 (16.7%)	1 (8.3%)
31 to 40	3 (25.0%)	4 (33.3%)
41 to 50	4 (33.3%)	7 (58.3%)
> 51	3 (25.0%)	-
Ethnicity		
Caucasian	6 (50.0%)	-
Chinese	4 (33.3%)	9 (75.0%)
Indian	-	1 (8.3%)
Malay	-	2 (16.7%)
Māori	1 (8.3%)	-
Pacific Island peoples	1 (8.3%)	-
Language ability		
English	11 (91.7%)	12 (100%)
English and other languages	1 (8.3%)	-
Religious affiliation		
Christians	3 (25.0%)	4 (33.3%)
Muslim	-	2 (16.7%)
Undisclosed	9 (75.0%)	6 (50.0%)

Note. All percentages are rounded off to one decimal place; hence the total percentage in each column may not be 100.

Age range

With data collapsed into two categories (i.e., below 40, and over 41 years of age), both countries had equal number of MHPs in the age group below 40 years (New Zealand 42%; Singapore 42%), and in the age group over 41 years (New Zealand 58%; Singapore 58%).

Ethnicity

On ethnicity, 50% of New Zealand MHPs compared with none from Singapore MHPs indicated they were Caucasian, whereas 33% from New Zealand MHPs compared with 75% of Singapore MHPs indicated they were Chinese.

Language ability

On language ability, 91% of New Zealand MHPs compared with 100% of Singapore MHPs indicated that English was their main language ability, whereas 8% of New Zealand MHPs compared with none from Singapore MHPs indicated that English and at least one other language were their main language ability. Generally, English is the medium used in therapy sessions by MHPs of both countries.

Religious affiliation

On religious affiliation, 25% of New Zealand MHPs compared with 33% of Singapore MHPs indicated Christianity. New Zealand's sample of participating MHPs is not representative of its normal population, which is predominantly Christian (over 50%; Statistics New Zealand, 2006). Singapore's sample of participating MHPs is also not representative of its population ratio, which is predominantly Chinese who are mainly Buddhists or Taoists (64%; Statistics Singapore, 2006).

Thus, similarities in personal and demographic characteristics between MHPs of both countries were found in terms of gender, age range, ethnicity and language ability. Differences between them were found in terms of religious affiliation.

Professional Characteristics (Training) of MHPs

Data collected from the structured interview on professional training of MHPs with respect to country of therapy training, qualification in therapy, number of years of supervised training received, registration of practice, and years of experience in therapy are shown in Table 7.10. Relevant comparisons are highlighted in the item-by-item analyses.

Country of therapy training

On country of therapy training, 50% of New Zealand MHPs compared with 17% of Singapore MHPs were trained in their own country. Many MHPs had their therapy training done in more than one country (New Zealand 42%; Singapore 58%). There was one MHP from Singapore who indicated having been trained in therapy in New Zealand.

Table 7.10
Professional Characteristics (Training) of New Zealand and Singapore Mental Health Practitioners (structured interview)

	New Zealand MHPs (N = 12)	Singapore MHPs (N = 12)
Country of therapy training		
Malaysia	-	1 (8.3%)
New Zealand	6 (50.0%)	-
Singapore	-	2 (16.7%)
UK	1 (8.3%)	-
USA	-	2 (16.7%)
More than 1 country	5 (41.7%)	7 (58.3%)
Qualification in therapy		
Bachelor's Degree	1 (8.3%)	1 (8.3%)
Masters Degree	5 (41.7%)	6 (50.0%)
Doctorate Degree	-	1 (8.3%)
Post-graduate Diploma	3 (25.0%)	1 (8.3%)
Multiple[a]	3 (25.0%)	3 (25.0%)
Number of years of supervised training received		
One year	-	2 (16.7%)
One and one half years	-	1 (8.3%)
Two	8 (66.7%)	8 (66.7%)
Three	3 (25.0%)	1 (8.3%)
Six and over	1 (8.3%)	-
Registration of practice		
Yes	9 (75.0%)	2 (16.7%)[b]
No	2 (16.7%)	-
Undisclosed	1 (8.3%)	-
Not applicable	-	10 (83.3%)
Years of experience in therapy		
1-10	6 (50.0%)	7 (58.3%)
11-20	4 (33.3%)	5 (41.7%)
> 21	2 (16.7%)	-

Note. All percentages are rounded off to one decimal place; hence the total percentage in each column may not be 100.
[a]Multiple qualifications did not indicate specific qualification in therapy. [b]Only psychiatrists are required to register their practice in Singapore.

Qualification in therapy

On qualification in therapy, 42% of New Zealand MHPs compared with 50% of Singapore MHPs held a masters degree, and 25% of New Zealand MHPs compared with 8% of Singapore MHPs held a post-graduate diploma. All percentages would increase if multiple qualifications were considered, but exact numbers were indeterminable due to a lack of specificity.

Years of supervised training received

In general, MHPs of both countries had about two to three years of supervision in their therapy training (New Zealand, 92%; Singapore, 75%).

Registration of practice

On registration of practice, 75% of New Zealand MHPs were registered for practice with their respective professional body, for example, the New Zealand Association of Counsellors; the rest who were not registered were awaiting approval or were registered with a non-therapy body. All Singapore MHPs registered for practice were psychiatrists (17%)—in Singapore, only medically trained professionals are required to register their practice.

Years of experience in therapy

On years of experience, 50% of New Zealand MHPs compared with 58% of Singapore MHPs had less than 10 years of experience in therapy, 33% of New Zealand MHPs compared with 41% of Singapore MHPs had between 11 and 20 years of experience in therapy, whereas 17% of New Zealand MHPs compared with none from Singapore MHPs had over 21 years of experience in therapy.

Thus, similarities in professional training characteristics between MHPs of both countries were found in terms of qualification in therapy, and years of supervised training received. Differences between them were found in terms of registration of practice. Data on country of therapy training and years of experience in therapy were inconclusive.

Professional Characteristics (Primary Job Affiliation and Use of Western Therapy Models and Interventions) of MHPs

Data collected from the structured interview on professional characteristics of MHPs concerning primary job affiliation, and use of Western therapy models and interventions are shown in Table 7.11. Relevant comparisons are highlighted in the item-by-item analyses.

Primary job affiliation

On primary job affiliation for both countries, comparative differences were seen in two categories of MHPs: 42% of New Zealand MHPs compared with 25% of Singapore MHPs were counsellors; and 8% of New Zealand MHPs compared with 25% of Singapore MHPs were social workers.

Use of Western therapy models

As observed, among the Western therapy models, 83% of New Zealand MHPs and 42% of Singapore MHPs endorsed the cognitive model, and 33% of New Zealand MHPs compared with 8% of Singapore MHPs endorsed the Rogerian model.

Table 7.11
Professional Characteristics (Primary Job Affiliation and Use of Western Therapy Models and Interventions) of New Zealand and Singapore Mental Health Practitioners (structured interview)

	New Zealand MHPs (N = 12)	Singapore MHPs (N = 12)
Primary Job Affiliation		
Counsellor	5 (41.7%)	3 (25.0%)
Psychiatrist	1 (8.3%)	2 (16.7%)
Psychologist	4 (33.3%)	3 (25.0%)
Psychotherapist	1 (8.3%)	1 (8.3%)
Social Worker	1 (8.3%)	3 (25.0%)
Use of Western therapy models as observed[a, b]		
Behaviour model	1 (8.3%)	1 (8.3%)
Cognitive model	10 (83.3%)	5 (41.7%)
Eclectic/Integrative model	-	1 (8.3%)
Psychoanalytic/Psychodynamic model	2 (16.7%)	1 (8.3%)
Rogerian model	4 (33.3%)	1 (8.3%)
Frequency of use of therapy interventions as observed[a, b]		
Behavioural management		
Cognitive therapy	1 (8.3%)	2 (16.7%)
Cognitive-behavioural therapy	1 (8.3%)	-
Family therapy	10 (83.3%)	5 (41.7%)
Marital therapy	2 (16.7%)	2 (16.7%)
	1 (8.3%)	-

Note. All percentages are rounded off to one decimal place; hence the total percentage in each column may not be 100.
[a]Participants indicated usage without frequencies in their verbal responses during the interview. [b]Multiple endorsements are allowed; hence total percentage of column may add up to more than 100.

Use of Western therapy interventions

As observed, among the Western therapy interventions, cognitive behaviour therapy was also endorsed by 83% of New Zealand MHPs and 42% of Singapore MHPs.

Thus, similarities in professional characteristics between MHPs of both countries were found in terms of use of Western therapy models and interventions. Differences between them were found in terms of primary job affiliation.

Practice Characteristics (Practice Setting) of MHPs

Data collected from the structured interview on practice characteristics (practice setting) of MHPs with respect to employment status, primary work setting, focus of practice, and "fees" of MHPs are shown in Table 7.12. "Fees" of MHPs is a special item obtained from the structured interview. Relevant comparisons are highlighted in the item-by-item analyses.

Employment status

On employment status, 75% of New Zealand MHPs compared with 25% of Singapore MHPs were working in the public sector, 8% of New Zealand MHPs compared with 42% of Singapore MHPs were in private practice (inclusive of self-employment), whereas 17% of New Zealand MHPs compared with none from Singapore MHPs were in private practice or self-employed and simultaneously working in a government setting.

Primary work setting

On primary work setting, 83% of New Zealand MHPs compared with 50% of Singapore MHPs were working in outpatient or community care, whereas 17% of Singapore MHPs compared with none from New Zealand MHPs were working in in-patient care.

Focus of practice

On focus of practice, 58% of New Zealand MHPs compared with 92% of Singapore MHPs indicated they were providing therapy services across all client groups.

Table 7.12
Practice Characteristics (Practice Setting) of New Zealand and Singapore Mental Health Practitioners (structured interview)

	New Zealand MHPs (N = 12)	Singapore MHPs (N = 12)
Employment status		
Government	9 (75.0%)	3 (25.0%)
Private	1 (8.3%)	5 (41.7%)
Combination of above	2 (16.7%)	-
Others	-	4 (33.3%)
Primary work setting		
In-patient	-	2 (16.7%)
Out-patient/Community	10 (83.3%)	6 (50.0%)
Combination of above	2 (16.7%)	4 (33.3%)
Focus of practice		
Adolescents	2 (16.7%)	1 (8.3%)
Adults	2 (16.7%)	-
Geriatrics	1 (8.3%)	-
Combination of above	7 (58.3%)	11 (91.7%)

Note. All percentages are rounded off to one decimal place; hence the total percentage in each column may not be 100.

Fees (in New Zealand dollars)

On fees chargeable for a therapy session in private practice, the following information were obtained from the participating MHPs of both countries: by a counsellor (New Zealand $80-90/hour plus GST; Singapore $120-125/hour), by a social worker with therapy training (New Zealand $80-100/hour plus GST; Singapore, not available), by a clinical psychologist (New Zealand $135/hour; Singapore $120-$150/hour) and a psychiatrist (New Zealand $250/hour; Singapore $200-$220/hour). The exchange rate then was almost on par, with New Zealand $1.00 to Singapore $1.02.

Thus, similarities in practice characteristics between MHPs of both countries were found in therapist fees. Differences between them were found in terms of employment status and primary work setting. Data on focus of practice was inconclusive.

Practice Characteristics (Diagnostic System and Assessment Procedures) of MHPs

Data collected from the structured interview on practice characteristics of MHPs concerning diagnostic system and use of assessment procedures are shown in Table 7.13. Relevant comparisons are highlighted in the item-by-item analyses.

Table 7.13
Practice Characteristics (Diagnostic System and Assessment Procedures) of New Zealand and Singapore Mental Health Practitioners (structured interview)

	New Zealand MHPs (N = 12)	Singapore MHPs (N = 12)
Diagnostic system used in practice		
Use of DSM IV	10 (83.3%)	5 (41.7%)
Others	-	3 (25.0%)
Undisclosed	2 (16.7%)	4 (33.3%)
Frequency of use of assessment procedures as observed[a, b]		
Wechsler Scales	2 (16.7%)	5 (41.7%)
Depression/Anxiety Scales	10 (83.3%)	1 (8.3%)

Note. All percentages are rounded off to one decimal place; hence the total percentage in each column may not be 100.
[a]Participants indicated usage without frequencies in their verbal responses during the interview. [b]Multiple endorsements are allowed; hence total percentage of column may add up to more than 100.

Diagnostic system

On diagnostic system, 83% of New Zealand MHPs compared with 42% of Singapore MHPs had used mainly the DSM IV. The lower percentage obtained for the Singapore sample was partly due to the fact that 33% did not indicate their views on it compared with 17% from New Zealand MHPs who did not do so.

Use of assessment procedures

As observed, the Wechsler Scales were endorsed by 17% of New Zealand MHPs and 42% of Singapore MHPs, and the depression/anxiety scales were endorsed by 83% of New Zealand MHPs and 8% of Singapore MHPs. Notably, the responses of both MHPs here were mutually exclusive.

Thus, similarities in practice characteristics between MHPs of both countries were found in terms of diagnostic system and use of assessment procedures. No differences between them were found.

Practice Characteristics (Client and Caseload) of MHPs

Data collected from the structured interview on practice characteristics (client and caseload) of MHPs with respect to clients seen, clients' presenting problems, and average number of sessions per client are shown in Table 7.14. Relevant comparisons are highlighted in the item-by-item analyses.

Clients seen

In 2001, the clients seen by MHPs of both countries were different ethnically and in numbers. Mainly Caucasian and Chinese clients were seen by 17% each of New Zealand MHPs, and fewer Māori clients by 8% of them. Mainly Chinese clients were seen by 83% of Singapore MHPs, fewer Indian clients by 42% of them, and fewer Malay clients by 33% of them.

Clients' presenting problems

The presenting problems of clients were categorized as per the DSM IV categories on the questionnaire. As observed, three frequently presented problems of their clients identified by MHPs of both countries were: anxiety (New Zealand, 75%; Singapore, 25%), behavioural problems (New Zealand, 25%; Singapore, 42%), and major depression (New Zealand, 75%; Singapore, 50%). Generally, clients' presenting problems were seen according to types and location of services offered by MHPs.

Table 7.14
Practice Characteristics (Client and Caseload) of New Zealand and Singapore Mental Health Practitioners (structured interview)

		New Zealand MHPs (N = 12)	Singapore MHPs (N = 12)
Frequency of clients seen in total practice time in 2001[a, b] (with % of time in [])			
Caucasian	[≤ 30%]	-	3 (25.0%)
	[≥ 40%]	2 (16.7%)	-
Chinese	[≤ 30%]	2 (16.7%)	-
	[≥ 40%]	2 (16.7%)	10 (83.3%)
Indians	[≤ 30%]	2 (16.7%)	5 (41.7%)
Malays	[≤ 50%]	-	4 (33.3%)
Māori	[≤ 50%]	1 (8.3%)	-
Clients' presenting problems as observed[b, c]			
Anxiety		9 (75.0%)	3 (25.0%)
Attention Deficit Disorder		2 (16.7%)	1 (8.3%)
Behavioural problems		3 (25.0%)	5 (41.7%)
Eating disorder		2 (16.7%)	1 (8.3%)
Major Depression		9 (75.0%)	6 (50.0%)
Marital problems		3 (25.0%)	1 (8.3%)
Obsessive-compulsive Disorder		1 (8.3%)	-
Panic Disorder		1 (8.3%)	-
Personality Problems		1 (8.3%)	-
Phobia		-	1 (8.3%)
Schizophrenia		-	1 (8.3%)
Substance Abuse		-	1 (8.3%)
Clients' problems outlined by 1 country only			
Financial problems		-	1 (8.3%)
Parenting issues		-	2 (16.7%)
Sexual abuse and related PTSD		1 (8.3%)	-
Average number of sessions per client as observed[d]			
≤ 5		-	1 (8.3%)
6-10		-	1 (8.3%)
≥ 11		1 (8.3%)	-

Note. All percentages are rounded off to one decimal place; hence the total percentage in each column may not be 100.
[a]Participants were asked to indicate frequency of use between 0-100% of time. Only frequencies of significance are tabled here. [b]Multiple endorsements are allowed; hence total percentage of column may add up to more than 100. [c]Participants indicated usage without frequencies in their verbal responses during the interview. [d]Participants indicated these usage in their verbal responses during the interview.

Average number of sessions per client

With data collapsed into two categories (i.e., 10 sessions or less, and 11 sessions or more), none from New Zealand MHPs compared with 17% of Singapore MHPs had an average of 10 sessions or less per client, whereas 8% of New Zealand MHPs compared with none from Singapore MHPs had an average of 11 sessions or more per

client. Although the sample was small, New Zealand MHPs again reported more therapy sessions with their clients than Singapore MHPs reported with theirs.

Other interesting observations were made of the MHPs on this topic. On the use of CBT model, the average number of sessions per client was 12. As to the length of short-term therapy, New Zealand MHPs would define that to mean 10 to 20 sessions, whereas Singapore MHPs would define that to mean 6 sessions or less. On help-seeking behaviours, female clients were found more willing to seek counselling than male clients.

Thus, similarities in practice characteristics between MHPs of both countries were found in clients seen and clients' presenting problems. Differences between them were found in terms of average number of sessions per client.

Nine themes were deduced from the views of these MHPs specifically on Chinese clientele. One, these clients were at different levels of Westernisation or acculturation. For example, those who were adherent to strict Chinese values and rules would speak little and show less emotion during therapy. Two, most knew little of therapy except for students in schools who learnt about it on orientation days. Hence, it was important to establish rapport with them early in therapy, look immediately at needs, and made use of psycho-education. Three, they believed life events are more externally control than by the self. For example, when caught speeding, the Chinese client would exclaimed, "Oh, I'm the most unlucky person in life". Four, they had high regard for hierarchy and respect authority. Hence, the therapist was treated as the expert or teacher. Five, they were pragmatic in that there was no such thing as talking therapy, few therapy sessions, say 6, would be sufficient, value for money, and came in when the

problem was acute. Hence, CBT might be a suitable model for short-term therapy with them. Six, treatment for them would preferably include use of their cultural teachings, proverbs, and slang or folk stories. Seven, they were a collectivistic culture. Hence, it was advisable to involve the family members in therapy, as well as traditional healing practices. Eight, they might present in sessions with physical symptoms than mental ones. Nine, in problem-solving with these clients, taking the middle ground or moderation might be viable. For example, in a conflict of interests between the Chinese father and son, in which the father wanted the son to study business but the son longed to be a teacher, a viable solution could be for the son to study business first then take up teaching.

Practice Characteristics (Experiential Skills) of MHPs

Data collected from the structured interview on practice characteristics (experiential skills) of MHPs with respect to preference for Western therapy models, relevance of Western therapy models to population, and therapists' handling of self-disclosure, religious or spiritual issues, and traditional healers are shown in Table 7.15. Relevant comparisons are highlighted in the item-by-item analyses.

Preference for Western therapy models

On preference for Western therapy models, 67% of New Zealand MHPs and 50% of Singapore MHPs indicated that their preference were based on empirical evidence and professional training, whereas 33% of New Zealand MHPs compared with 17% of Singapore MHPs indicated that the preference were based on those of the clients rather than theirs.

According to the MHPs, Western therapy models prevailed in New Zealand and Singapore as indigenous therapy models existed but were not fully developed: for example, "Just Therapy" for Māori (Waldegrave, Tamasese, Tuhaka, & Campbell, 2003), and "PADI" for Singaporeans (an acronym for Problem, Attempted Solution, Decision, Intervention by Yeo, 1993; Singapore Psychological Society, personal communication, July 31, 2002). Studies on these indigenous therapy models are lacking as they were rather new. Furthermore, Singapore-trained MHPs indicated that there was no available clinical psychology programme in Singapore, and that their therapy orientations were those of Western therapy models. Their therapy training included supervision that was conducted formally by institutions or informally within their organisations.

Relevance of Western therapy models to population

In general, Western therapy models were rated moderate by MHPs from both countries (New Zealand, 50%; Singapore, 58%) to be at least 50% relevant to their own population but modified for use with non-Caucasian ethnic groups.

Six themes were deduced from the views of these MHPs on the relevance of Western therapy models. First of all, the models were found integrating and answering to specific disorders. For example, the Rogerian approach might be useful universally for establishing initial rapport with the client. Secondly, the models were found modifiable for all cultures. For example, the cognitive approach is suitable for high functioning clients, whereas the behaviour approach is suitable for low functioning clients. Thirdly, the therapist-client relationship was a major factor in the accomplishment of therapy. Fourthly, lifestyles of peoples were becoming more stressful and they would want their psychological needs met. Fifthly, the therapist had to be flexible in engaging clients especially from different cultures. For example,

present and use models according to the client's issues. Lastly, clients had the ultimate choice for therapy.

Table 7.15
Practice Characteristics (Experiential Skills) of New Zealand and Singapore Mental Health Practitioners (structured interview)

	New Zealand MHPs (N = 12)	Singapore MHPs (N = 12)
Western therapy model preference based on		
Empirical evidence/training	8 (66.7%)	6 (50.0%)
Client's personal preference	4 (33.3%)	2 (16.7%)
Combination of above	-	4 (33.3%)
Western therapy models are ≥50%[a] relevant to population, but modified for use with non-Caucasian ethnic groups	6 (50.0%)[b]	7 (58.3%)[b]
Therapist self-disclosure		
Agreeable with some in session	11 (91.7%)	11 (91.7%)
Not agreeable	-	-
Undisclosed	1 (8.3%)	1 (8.3%)
Religious/Spiritual Issues		
Agreeable to discuss and refer on	11(91.7%)	10 (83.3%)
Not agreeable	-	-
Undisclosed	1 (8.3%)	2 (16.7%)
Traditional healers		
No objection to services	9 (75.0%)	8 (66.7%)
Objection to services	-	-
Other concerns	1 (8.3%)	2 (16.7%)
Undisclosed	2 (16.7%)	2 (16.7%)

Note. All percentages are rounded off to one decimal place; hence the total percentage in each column may not be 100.
[a]Participants were asked to indicate frequency of use between 0-100% of time. Only frequencies of significance are tabled here. [b]Figures represent the average for the 3 main ethnic groups in New Zealand (Caucasian, Māori and Pacific Island peoples) and Singapore (Chinese, Malay and Indian) respectively.

Therapists' handling of self-disclosure, religious or spiritual issues, and traditional healers

MHPs from both countries generally agreed that some or minimal self-disclosure in session was beneficial for the therapeutic relationship (New Zealand, 92%; Singapore, 92%). They also agreed to discuss clients' religious or spiritual issues in session and refer on to a person of religious qualification to handle the case if necessary (New Zealand, 92%; Singapore, 83%). Furthermore, they had no objection to the use of traditional healing services by clients (New Zealand, 75%; Singapore, 67%). They

indicated this to mean the possibility of having the traditional healer or healing practice in session where necessary. Those who had allowed the traditional healer in session had found the experience pleasant and helpful to the client.

Thus, similarities in practice characteristics between MHPs of both countries were found in relevance of Western therapy models to population, and therapists' handling of self-disclosure, religious or spiritual issues, and traditional healers. Differences between them were found in preference for Western therapy models.

Four themes were gleaned from the views of these MHPs on therapist self-disclosure. One, it was appropriate and beneficial, even therapeutic to the client. Two, it would put the client at ease, build rapport, achieve goals, illustrate a point or lead to a better understanding of the issue in question. Three, it was dependent on type of clients (usually with non-Caucasian) and stage of therapy (usually when familiar). Four, it usually involved sharing of professional information (e.g. qualifications), personal information (e.g. whether married with children; religious affiliation) or experience (whether client's problem had been experienced too) and some anecdotes. Examples of self-disclosure by MHPs were: "As a migrant too, I…", and "I remember when I had a fight with my father…".

Four themes were gleaned from the views of these MHPs on handling religious or spiritual issues of the client. One, it was a respect of the client's faith or belief system. Two, it was acceptable and helpful to discuss them if the client brought it up. Three, it would lead to a better understanding of the client. Four, it would be referred on to a religious person if beyond therapy. Examples on handling of religious or spiritual issues cited by MHPs were: the observance of prayers by Christian, Muslim or Māori

clients with the presence of the family or traditional healer; the reference of a Christian client with depression and another with post-traumatic stress disorder to their respective church for assistance; the use of more than one MHP to work separately with family members from a staunch religious background; and use of references to teachings of Confucianism, Taoism, Buddhism, or Christianity to match clients' beliefs and perception of problems.

On the other hand, MHPs noted that disagreement to discussing religious issues in session would be a matter of conflict of interests or beliefs. Examples of such cited by MHPs were: the client could refuse to share his or her "sinful past", rather bottling up conflicts for fear of ridicule; and the religious person might advise the client against medication and therapy.

Three themes were gleaned from the views of these MHPs on handling traditional healing services of the client. One, it was a respect of the client's cultural or value system. Two, it was generally acceptable, helpful but might be kept separate from therapy. Three, the therapist would be consulted first.

Various traditional healing practices cited by MHPs were: acupuncture, aromatherapy, exercise, foot reflexology, fortune-telling, geomancy, herbal medicine, massage therapy, meditation, mindfulness techniques, praying, relaxation exercises, religious counselling, shamanism, Tai Chi, tonic drinks, and yoga. Various traditional healers cited by MHPs were bomohs (Malay faith healers), fortune-tellers, geomancers, tohunga (Māori spiritual healer), ministers, monks, pastors, priests, shamans (Chinese faith healers), and temple mediums. For example, a Māori spiritual healer would treat mental illness with chanting, prayers, and use of water to cleanse away the evil, the bad things, and violations. Once, a Māori girl had symptoms of dissociation and was

hearing voices of her grandfather. After visiting a Māori spiritual healer and told to remove a bone carving she was wearing around her neck, her symptoms disappeared.

MHPs also cited the following objectives by clients on the use of traditional healing practices. One, symptom relief from stress, anxiety or depression could be obtained through acupuncture, aromatherapy, massage therapy, meditation, mindfulness techniques, Tai Chi, or yoga. For example, the therapy room could be saturated with scented oils as part of aromatherapy. Two, a peace of mind and a positive attitude towards life could be obtained through prayers, visiting the geomancer, fortune-teller or temple medium. Three, side effects of Western medication could be reduced with the consumption of traditional herbal medicine, for example, Chinese medicine.

On the other hand, MHPs also questioned the effectiveness and drawbacks of traditional healing practices. For example, a client became emotional after visiting a meditation master as her childhood memories were evoked, in which psychotherapy was disrupted. An autistic child with monkey-like behaviours was hit with a wooden clog at a Chinese temple—a process similar to exorcism. A hyperactive child's health was in bad shape after being treated with herbs by a bomoh. The consumption of St John's Wort, a kind of herbs used by indigenous peoples of New Zealand, brought with it the side effects of bad gastrointestinal pain and headaches. Furthermore, the client might attribute relief of anxiety to the traditional practices, or use them as safety behaviours. There was also the danger of scams like "crystal therapy"—an inert crystallised stone claimed by the "traditional healer" to have healing powers.

PART III: COMBINED RESULTS FROM MAIL QUESTIONNAIRE AND STRUCTURED INTERVIEW

Part III presents the combined results from Parts I and II, constituting the main findings of the study, in the order of the research hypotheses. Personal, professional, and practice characteristics of MHPs of Parts I and II will be reconstituted to suit the hypotheses in question. As mentioned earlier, detailed analyses are undertaken hereon, as a logical step since both quantitative and qualitative data were present in Studies I and II. It also underscores and realises the strength of the mixed design (e.g. Greene & Caracelli, 1997; Neuman, 2003; Taylor, 2000; Todd, Nerlich, & McKeown, 2004; Woolfe, Dryden, & Strawbridge, 2003). Non-parametric inferential statistics, namely, the Pearson chi-square, was performed on select data as appropriate (Barrett, 2001).

Despite the relatively small sample sizes obtained from Part I of the study, the data was nonetheless of considerable values and certainly supported by the data from Part II. Focus on small-N research has always been an important factor of research in psychology, and has recently been advocated as a vital source of information that might otherwise be lost (Blampied, 2001).

Hypothesis 1 (Therapist Characteristics)

It is hypothesised that personal, professional and practice characteristics of New Zealand and Singapore MHPs would be representative of their characteristics in their respective country. Related data are presented in two tables for ease of presentation. Table 7.16 shows the practice and professional characteristics of all participating MHPs from both countries with respect to primary job affiliation, employment status, primary work setting, and focus of practice. Table 7.17 shows their personal and demographic

characteristics with respect to gender, age range, ethnicity, language ability, religious affiliation.

Table 7.16
Practice Characteristic (Primary Job Affiliation) and Professional Characteristics of New Zealand and Singapore Mental Health Practitioners (combined results)

	New Zealand MHPs (N = 53)	Singapore MHPs (N = 73)
Primary Job Affiliation		
Counsellor	7 (13.2%)	22 (30.1%)
Psychiatrist	3 (5.7%)	13 (17.8%)
Psychologist	33 (62.3%)	11 (15.1%)
Psychotherapist	5 (9.4%)	3 (4.1%)
Social Worker	3 (5.7%)	22 (30.1%)
Multiple role	2 (3.8%)	2 (2.7%)
Employment status		
Government	22 (41.5%)	21 (28.8%)
Private	8 (15.1%)	38 (52.1%)
Self-employed	8 (15.1%)	5 (6.8%)
Combination of above	15 (28.3%)	-
Others	-	7 (9.6%)
Undisclosed	-	2 (2.7%)
Primary work setting		
In-patient	2 (3.8%)	8 (11.0%)
Out-patient/Community	25 (47.2%)	30 (41.1%)
Private practice	14 (26.4%)	8 (11.0%)
Training	1 (1.9%)	2 (2.7%)
Combination of above	9 (17.0%)	18 (24.7%)
Others	2 (3.8%)	5 (6.8%)
Undisclosed	-	2 (2.7%)
Focus of practice		
Children	1 (1.9%)	4 (5.5%)
Adolescents	2 (3.8%)	11 (15.1%)
Adults	31 (28.3%)	16 (21.9%)
Geriatrics	1 (1.9%)	1 (1.4%)
Combination of above	18 (34.0%)	38 (52.1%)
Others	-	2 (2.7%)
Undisclosed	-	1 (1.4%)

Note. All percentages are rounded off to one decimal place; hence the total percentage in each column may not be 100.

As shown in Table 7.16, comparative differences were found in three categories of New Zealand and Singapore MHPs with regard to their primary job affiliation: 13% of New Zealand MHPs compared with 30% of Singapore MHPs were counsellors; 62% of New Zealand MHPs compared with 15% of Singapore MHPs were psychologists; and 6% of New Zealand MHPs compared with 30% of Singapore MHPs were social workers. However, both countries have as many counsellors as psychologists (Foo &

Merrick, 2004). Thus, representative samples of these participating MHPs were not obtained.

On employment status, 42% of New Zealand MHPs compared with 29% of Singapore MHPs were in the public service, 30% of New Zealand MHPs compared with 59% of Singapore MHPs were in private practice (inclusive of self-employment), whereas 28% of New Zealand compared with none from Singapore who were in private practice or self-employed and simultaneously working in a government setting. In New Zealand, an MHP can work in both private and public settings at the same time, whereas in Singapore, an MHP working for the government is not allowed to hold another employment. The results on employment status of MHPs are inconclusive.

On primary work setting, 47% of New Zealand MHPs and 41% of Singapore MHPs were working in outpatient or community care, whereas 26% of New Zealand compared with 11% of Singapore MHPs were in private practice. As mentioned, a discrepancy between the data on private (in "Employment status") and private practice (in "Primary work setting") indicated by MHPs of both countries occurred because of the possible combinations of the items indicated—for example, "Self-employed" was checked with "Private practice"; "Private" was checked with "Outpatient/ Community" but not with "Private practice". Putting "Primary Work Setting" together with "Employment status", it was evident that more New Zealand MHPs were working in the public sector than the private sector, whereas slightly more Singapore MHPs were working in the private sector than the public sector. The results on primary work setting are inconclusive.

On the focus of practice, 4% of New Zealand MHPs compared with 15% of Singapore MHPs indicated they were providing therapy services mainly for adolescent clients, 28% of New Zealand MHPs and 22% of Singapore MHPs were providing

therapy services mainly for adult clients, whereas 34% New Zealand MHPs compared with 52% of Singapore MHPs indicated they were providing therapy services across all client groups. Generally, the results on focus of practice do reflect that mental health services in New Zealand and Singapore have their focus on the adult population.

Table 7.17
Personal and Demographic Characteristics of New Zealand and Singapore Mental Health Practitioners (combined results)

	New Zealand MHPs (N = 53)	Singapore MHPs (N = 73)
Gender		
Female	31 (58.5%)	51 (69.9%)
Male	22 (41.5%)	22 (30.1%)
Age range		
20-30	3 (5.7%)	19 (26.0%)
31-40	11 (20.8%)	24 (32.9%)
41-50	20 (37.7%)	24 (32.9%)
> 51	19 (35.8%)	6 (8.2%)
Ethnicity		
Caucasian	45 (84.9%)	3 (4.1%)
Chinese	4 (7.5%)	57 (78.1%)
Eurasian	-	1 (1.4%)
Filipino	1 (1.9%)	-
Indian	1 (1.9%)	7 (9.6%)
Malay	-	5 (6.8%)
Māori	1 (1.9%)	-
Pacific Island peoples	1 (1.9%)	-
Language ability		
Chinese	-	1(1.4%)
English	38 (71.7%)	19 (26.0%)
Malay	-	1 (1.4%)
Tagalog	1 (1.9%)	-
English and other languages	13 (24.5%)	52 (71.2%)
Undisclosed	1 (1.9%)	-
Religious affiliation		
Buddhist	3 (5.7%)	5 (6.8%)
Christian	16 (30.2%)	50 (68.5%)
Hindu	-	2 (2.7%)
Muslim	-	5 (6.8%)
Multiple	3 (5.7%)	-
None	19 (35.8%)	4 (5.5%)
Undisclosed	12 (22.6%)	7 (9.6%)

Note. All percentages are rounded off to one decimal place; hence the total percentage in each column may not be 100.

As shown in Table 7.17, for both countries, the numbers of responses from female MHPs (New Zealand, 59% and Singapore, 70%) were higher than those of male

MHPs (New Zealand, 42%; Singapore, 30%). The results on gender reflect that MHPs in New Zealand are higher in female numbers, whereas for MHPs in Singapore, they are not affirmed.

With data collapsed into two categories (below 40 and over 41 years of age), 27% of New Zealand MHPs compared with 59% of Singapore MHPs were in the age group below 40 years (there was significant difference between the groups, $\chi 2 = 5.18$, [df =1, $p \leq 0.025$]), whereas 74% of New Zealand MHPs compared with 41% of Singapore MHPs were in the age group over 41 years (there was no significant difference between the groups, $\chi^2 = 3.74$, [df =1, $p \leq 0.10$]). The age range of MHPs of both countries is different.

On their ethnicity, comparative differences were seen in three categories of MHPs: 85% of New Zealand MHPs compared with 4% of Singapore MHPs indicated they were Caucasian; 8% of New Zealand MHPs compared with 78% of Singapore MHPs indicated they were Chinese; and 2% of New Zealand MHPs compared with 10% of Singapore MHPs indicated they were Indian. New Zealand MHPs included Māori and Samoan MHPs (2% each) that were not reported among Singapore MHPs, whereas Singapore MHPs included Eurasian (1%) and Malay (7%) that were not present among New Zealand MHPs. Both samples of participating MHPs, however, are representative of the general ethnic ratio in their own country (Statistics New Zealand, 2006; Statistics Singapore 2006).

On language ability, 72% of New Zealand MHPs compared with 26% of Singapore MHPs indicated that English was their main language ability, whereas 25% of New Zealand MHPs compared with 71% of Singapore MHPs indicated that English and at least one other language were their main language ability. Generally, English was the medium used in therapy sessions by MHPs of both countries. Singapore MHPs had

also to use other languages because of the composition of its population, though English was made its common language since 1981 (Ang, 2001; Gupta, 1994).

On their religious affiliation, 30% of New Zealand MHPs compared with 69% of Singapore MHPs indicated Christianity. New Zealand's sample of participating MHPs is unlike its normal population, which is predominantly Christian (over 50%; Statistics New Zealand, 2006). Singapore's sample of participating MHPs is also unlike its population ratio, which is predominantly Chinese who are mainly Buddhists or Taoists (64%; Statistics Singapore, 2006).

Thus, similarities in characteristics of MHPs of both countries were found in focus of practice, gender, ethnicity, and language ability. Differences between them were found in primary job affiliation, age range, and religious affiliation. Data on employment status and primary work setting were inconclusive. However, similarities in characteristics of MHPs of both countries provide partial support to the hypothesis on therapist characteristics. Not supporting the hypothesis are the differences in therapist characteristics and the inconclusive data.

Hypothesis 2 (Therapist Training)

It was hypothesised that MHPs of both New Zealand and Singapore would have been trained in Western psychology and therapy, and that New Zealand is well established in clinical psychology. Table 7.18 shows the professional training characteristics of participating MHPs of both countries with respect to the country of therapy training, qualification in therapy, number of years of supervised training received, registration of practice, and years of experience in therapy.

Table 7.18
Professional Characteristics (Training) of New Zealand and Singapore Mental Health Practitioners (combined results)

	New Zealand MHPs (N = 53)	Singapore MHPs (N = 73)
Country of therapy training		
Australia	-	4 (5.5%)
Canada	-	1 (1.4%)
India	-	1 (1.4%)
Malaysia	-	1 (1.4%)
New Zealand	31 (58.5%)	-
Singapore	-	26 (35.6%)
South Africa	1 (1.9%)	-
United Kingdom	3 (5.7%)	2 (2.7%)
USA	-	8 (11.0%)
More than one country	18 (34.0%)	30 (41.1%)
Qualification in therapy		
Certificate	-	3 (4.1%)
Diploma	2 (3.8%)	3 (4.1%)
Bachelor's Degree	1 (1.9%)	11 (15.1%)
Masters Degree	13 (24.5%)	22 (30.1%)
Doctorate Degree	1 (1.9%)	2 (2.7%)
Post-graduate Diploma	17 (32.1%)	4 (5.5%)
Graduate Diploma	1 (1.9%)	-
Multiple[a]	18 (34.0%)	25 (34.2%)
Others	-	2 (2.7%)
Undisclosed	-	1 (1.4%)
Number of years of supervised training received		
One year	2 (3.8%)	8 (11.0%)
One and one half years	-	2 (2.7%)
Two	13 (24.5%)	25 (34.2%)
Three	13 (24.5%)	12 (16.4%)
Four	7 (13.2%)	8 (11.0%)
Four and a half years	-	1 (1.4%)
Five	4 (7.5%)	5 (6.8%)
Six and over	4 (7.5%)	8 (11.0%)
Undisclosed	10 (18.9%)	4 (5.5%)
Registration of practice		
Yes	47 (88.7%)	13 (17.8%)[b]
No	2 (3.8%)	-
Not appropriate	2 (3.8%)	-
Undisclosed	2 (3.8%)	-
Years of experience in therapy		
1-10	18 (34.0%)	51 (69.9%)
11-20	19 (35.8%)	15 (20.5%)
> 21	16 (30.2%)	7 (9.6%)

Note. All percentages are rounded off to one decimal place; hence the total percentage in each column may not be 100.
[a]Multiple qualifications did not indicate specific qualification in therapy. [b]Only psychiatrists are required to register their practice in Singapore.

On country of formal therapy training (i.e. at the university), 8% of New Zealand MHPs compared with 14% of Singapore MHPs were trained in one country overseas, whereas 59% of New Zealand MHPs compared with 36% of Singapore MHPs were trained in their own country. However, 34% of New Zealand MHPs and 41% Singapore MHPs were trained in more than one country, that is, in New Zealand or Singapore and one other country, or all overseas. Regardless of country of training, all MHPs were trained in Western psychology and therapy models.

On qualification in therapy, 2% of New Zealand MHPs compared with 15% of Singapore MHPs held a bachelor's degree, 25% of New Zealand MHPs and 30% of Singapore MHPs held a masters degree, and 32% of New Zealand MHPs compared with 6% of Singapore MHPs held a post-graduate diploma. All percentages would increase if the category on multiple qualifications were considered, but due to specifications not indicated by the participating MHPs, exact numbers were not available.

Generally, MHPs of both countries received between two and three years of supervised training in therapy (New Zealand, 49%; Singapore, 51%). The majority of post-graduate diploma holders from New Zealand were clinical psychologists who were trained in its clinical psychology programmes at the tertiary institutions. On the other hand, Singapore MHPs indicated that there were no formal institutionalised clinical psychology programmes in Singapore, and the existing clinical training in Singapore was by way of supervision that was conducted formally by institutions or informally within organisations (as mentioned in the article by Elliot, 1999). The higher percentage of New Zealand MHPs (19%), compared with 6% from Singapore MHPs did not disclose their years of supervised training received, was partly due to misreading of the item.

Among New Zealand MHPs, 89% were registered with their respective professional body. The remaining 11% who were not registered were awaiting approval or were registered with a non-therapy body. In New Zealand, it was customary for MHPs to register their practice but in Singapore only medically trained professionals were required to do so (Singapore Medical Association, 2003); in this study, 18% psychiatrists in Singapore had registered for their practice.

With data collapsed into two categories (leas than 10 years and over 11 years of experience), 34% of New Zealand MHPs compared with 70% of Singapore MHPs had less than 10 years of experience in therapy (there was significant difference between the groups, $\chi 2 = 4.92$, [df =1, $p \leq 0.05$]), whereas 66% of New Zealand MHPs compared with 30% of Singapore MHPs had well over 11 years of experience in therapy (there was significant difference between the groups, $\chi 2 = 5.88$, [df =1, $p \leq 0.025$]).

Thus, similarities in characteristics of MHPs of both countries were found in country of therapy training, qualification in therapy, and number of years of supervised training received. Differences between them were found in availability of clinical psychology programmes, registration of practice, and years of experience in therapy. However, data provide support to the hypothesis that MHPs of both New Zealand and Singapore have been trained in Western psychology and therapy, and that New Zealand is well established in clinical psychology.

Hypothesis 3 (Suitability of Western Therapy Models)

It was hypothesised that the application of Western therapy models with non-Westerners would entail some form of modification. These modifications would have been carried out by New Zealand and Singapore by MHPs on their non-Caucasian clients (e.g., Chinese clients), and especially for Singapore where mainly Asians reside. It was further hypothesised that if these models were suitable for treatment of non-Caucasian clients, there would be fewer clients' requests for therapist-client gender or ethnic match. Related data are presented in two tables for ease of presentation. Table 7.19 shows the professional characteristics of participating MHPs from both countries with respect to use of Western therapy models and interventions. Table 7.24 shows their practice characteristics with respect to relevance and preferences of therapy models and gender/ethnic match.

As shown in Table 7.19, the three Western therapy models identified by MHPs of both countries that were mainly used at least 50% of total practice time were: the behaviour model (New Zealand, 60%; Singapore, 59%), the cognitive model (New Zealand, 79%; Singapore, 62%), and the eclectic/integrative model (New Zealand, 51%; Singapore, 48%). If observations from the interview samples were included (row 2 of Table 7.19), usage for the cognitive model would be much higher (up to 98%). For a full listing of the "Frequency of Western Therapy Models in Use" by all participating MHPs, see Appendix I.

Table 7.19
Professional Characteristics (Use of Western Therapy Models and Interventions) of New Zealand and Singapore Mental Health Practitioners (combined results)

	New Zealand MHPs (N = 53)	Singapore MHPs (N = 73)
Western therapy models used ≥50% of total time in practice[a, b]		
Behaviour model	32 (60.4%)	43 (58.9%)
Cognitive model	42 (79.2%)	45 (61.6%)
Eclectic/Integrative model	27 (50.9%)	35 (47.9%)
Humanistic model	18 (34.0%)	22 (30.1%)
Interpersonal model	23 (43.4%)	27 (37.0%)
Psychoanalytic/Psychodynamic model	18 (34.0%)	17 (23.3%)
Rogerian model	20 (37.7%)	27 (37.0%)
Use of Western therapy models as observed[c]		
Cognitive model	10 (83.3%)	5 (41.7%)
Use of therapy interventions ≤ 30% of time in practice[a, b]		
Behavioural management	22 (41.5%)	28 (38.4%)
Brief therapy	15 (28.3%)	20 (27.4%)
Cognitive therapy	18 (34.0%)	20 (27.4%)
Cognitive-behavioural therapy	14 (26.4%)	24 (32.9%)
Family therapy	15 (28.3%)	25 (34.2%)
Marital therapy	22 (41.5%)	25 (34.2%)
Psychoeducation	18 (34.0%)	17 (23.3%)
Relaxation	21 (39.6%)	19 (26.0%)
Stress management	13 (24.5%)	24 (32.9%)
Use of therapy interventions observed[c]		
Cognitive-behavioural therapy	10 (83.3%)	5 (41.7%)

Note. All percentages are rounded off to one decimal place; hence the total percentage in each column may not be 100.
[a]Participants were asked to indicate frequency of use between 0-100% of time. Only frequencies of significance are tabled here. [b]Multiple endorsements are allowed; hence total percentage of column may add up to more than 100. [c]Participants indicated usage without frequencies in their verbal responses during the interview.

Further cross-comparisons on the choices of Western therapy models in use by MHPs of both countries did not show specific orientation by specific groups of MHPs, whether counsellors, psychiatrists, psychologists or social workers (see Tables 7.20 to 7.23).

Table 7.20
Therapy Model Orientation of New Zealand and Singapore Counsellors (combined results)

	Most of the time		> half of time		50/50 of time		< half of time		Not at all		No time indicated	
	NZ	SG	NZ	SG	NZ	SG	NZ	SG	NZ	SG	NZ	SG
Alderian				1		2		2	1	4		
Behaviour		2		3		6	1	2		1		
Cognitive		5	1	5	1	3		2			2	
Eclectic/Integrative	1	6		3		3		1		1		
Existential	1	1		1	1	3		2		3		
Experiential	1	1		3	1	2		2		3		
Gestalt	1			2	1	3		4		1		
Humanistic	1	2	1	3		3		2		2		
Interpersonal	1	1	1	4		2		1		2		
Psychoanalytic/Psychodynamic				1	2	2		2	1	4		
Rogerian	1	4	1	4	1					2	2	

Note. NZ = New Zealand Counsellors (n = 7); SG = Singapore Counsellors (n = 22). Multiple endorsements are allowed.

Table 7.21
Therapy Model Orientation of New Zealand and Singapore Psychiatrists (combined results)

	Most of the time		> half of time		50/50 of time		< half of time		Not at all		No time indicated	
	NZ	SG	NZ	SG	NZ	SG	NZ	SG	NZ	SG	NZ	SG
Alderian							2	1	6			
Behaviour	1	2	1	5		4						
Cognitive	1	1	1	5		5					1	1
Eclectic/Integrative	1	4	1	6		1						
Existential	1		1	2		2		2		3		
Experiential						2		1	1	5		
Gestalt	1							1	1	6		
Humanistic	1			1			1	1		5		
Interpersonal				4	1	1	1			3		
Psychoanalytic/Psychodynamic			1	2	1	3		1		1		
Rogerian				1	1	4	1			2		

Note. NZ = New Zealand Psychiatrists (n = 3); SG = Singapore Psychiatrists (n = 13). Multiple endorsements are allowed.

Table 7.22
Therapy Model Orientation of New Zealand and Singapore Psychologists (combined results)

	Most of the time		> half of time		50/50 of time		< half of time		Not at all		No time indicated	
	NZ	SG	NZ	SG	NZ	SG	NZ	SG	NZ	SG	NZ	SG
Alderian		1					2	1	17	2		
Behaviour	5	2	11	1	8	1	3					1
Cognitive	18	3	11	1	2	1	1					2
Eclectic/Integrative	9	2	4	1	7		3		2	2		
Existential			2		6	2	6	1	7	1		
Experiential	1		2		5	2	7	1	6	1		
Gestalt					5	2	10	2	6			
Humanistic	1		1		11	3	6	1	4			
Interpersonal	1		4		11	3	5	1	1			
Psychoanalytic/Psychodynamic	3		4	1	2	1	10	1	5	1		
Rogerian	1		5		7	1	4	1	5	2		

Note. NZ = New Zealand Psychologists (n = 33); SG = Singapore Psychologists (n = 11). Multiple endorsements are allowed.

Table 7.23
Therapy Model Orientation of New Zealand and Singapore Social Workers (combined results)

	Most of the time		> half of time		50/50 of time		< half of time		Not at all		No time indicated	
	NZ	SG	NZ	SG	NZ	SG	NZ	SG	NZ	SG	NZ	SG
Alderian								2	2	12		
Behaviour		2	2	5		8		1		2		
Cognitive		1	2	4		8		2		3	1	1
Eclectic/Integrative	1	6		1		1		1		7		
Existential				3	1	3		2	1	8		
Experiential				4	1	4		1	1	7		
Gestalt						1	1	3	1	10		
Humanistic		2		3		4	1	2		6		
Interpersonal		3		3	1	5				3		
Psychoanalytic/Psychodynamic				3	1	2		2	1	7		
Rogerian		1		6	1	5		2	1	2		

Note. NZ = New Zealand Social Workers (n = 3); SG = Singapore Social Workers (n = 22). Multiple endorsements are allowed.

Six Western therapy interventions identified by MHPs from both countries that were used no more than 30% of practice time were: behaviour management (New Zealand, 42%; Singapore, 38%), cognitive therapy (New Zealand, 34%; Singapore, 27%), cognitive behaviour therapy (New Zealand, 26%; Singapore, 33%), marital therapy (New Zealand, 42%; Singapore 34%), psycho-education (New Zealand, 34%; Singapore, 23%), and relaxation (New Zealand, 40%; Singapore, 26%). If observations from the interview samples were included (row 4 of Table 7.19), usage for the cognitive behaviour therapy would be much higher (up to 45%). For a full listing of the "Frequency of Therapy Interventions in Use" by all participating MHPs, see Appendix J.

Table 7.24
Practice Characteristics (Preference and Relevance of Western Therapy Models, and Gender/Ethnic Match) of New Zealand and Singapore Mental Health Practitioners (combined results)

	New Zealand MHPs (N = 53)	Singapore MHPs (N = 73)
Western therapy model preference based on		
Empirical evidence/training	27 (50.9%)	15 (20.5%)
Practitioner's personal preference	5 (9.4%)	11 (15.1%)
Client's personal preference	11 (20.8%)	14 (19.2%)
Organisation's practice	-	1 (1.4%)
Combination of above[a]	7 (13.2%)	15 (20.5%)
Other concerns	1 (1.9%)	4 (5.5%)
Undisclosed	2 (3.8%)	13 (17.8%)
Western therapy models are ≥ 50%[b] relevant to population, but modified for use with non-Caucasian ethnic groups	37 (69.8%)[c]	49 (67.1%)[c]
Clients' frequency of request for same gender/ethnic therapist ≥ 50% of total practice time[b]	19 (35.8%)	17 (23.3%)
Client's reasons for above requests		
Cultural/Language issues	5 (9.4%)	8 (11.0%)
Client's personal preference	10 (18.9%)	7 (9.6%)
Comfort/Safety issues	4 (7.5%)	6 (8.2%)
Problem-based	11 (20.8%)	8 (11.0%)
Organisation's prerogative	1 (1.9%)	1 (1.4%)
Other concerns	5 (9.4%)	3 (4.1%)
Combination of above	4 (7.5%)	6 (8.2%)
Undisclosed	13 (24.5%)	33 (45.2%)

Note. All percentages are rounded off to one decimal place; hence the total percentage in each column may not be 100.
[a]"Combination of above" referred to practitioner's personal preference and one other preference.
[b]Participants were asked to indicate frequency of use between 0-100% of time. Only frequencies of significance are tabled here. [c]Figures represent the average for the 3 main ethnic groups in New Zealand (Caucasian, Māori and Pacific Island peoples) and Singapore (Chinese, Malay and Indian) respectively.

As shown in Table 7.24, 51% of New Zealand MHPs compared with 21% of Singapore MHPs indicated their preference for Western therapy models were based on empirical evidence and professional training, whereas 9% of New Zealand MHPs compared with 15% of Singapore MHPs indicated their preference were based on own preference rather than those of their clients. Eighteen percent of Singapore MHPs did not indicate their reasons for preference of Western therapy models compared with 4% from New Zealand MHPs who did not do so. Excerpts from statements made by MHPs

of both countries on their "Preference for Western Therapy Models" are given below (see Appendix K for a full listing of the statements made by all participating MHPs).

Sample Statements on "Preference for Western Therapy Models" by: New Zealand MHPs	Singapore MHPs
Empirical evidence/training	
• Demonstrated effectiveness (literature-based) outcome evidence. • Evidence-based practice guidelines for specific problems (what works for whom). • Based on training.	• Effectiveness/the potential for effectiveness. • Efficiency (what experience or empirical evidence had shown to work). • Professional training.
Practitioner's personal preference	
• According to my level of skill in addressing those needs. • Personal preference.	• Fits best with my life philosophy, principles, values and personality; makes sense, is practical and can see results. • I choose it on what I believe is of the most benefit to patients.
Client's personal preference	
• Client issues, personality, goals, needs. • The needs of the client, the gender and culture of the client.	• Based on the needs of the child. • Client's comfort/educational level.
Organisation's practice	
• --	• Agency mandate.
Other concerns	
• Its potential to reveal the client's constructs. • Results of initial assessment and diagnosis and age/developmental status of individual.	• Cost effective. Fits in with Singaporean mindset of fast results. • Spiritual.
Combination of above	
• Client/therapy match. • My own preferences according to my own wisdom and personal learning, b) a range of techniques to suit the personality style and problems of my patients.	• Agency's influence and effectiveness of therapy. • Good scientific evidence it is efficacious and I agree with its rationale.

Western therapy models were rated highly by MHPs from both countries (New Zealand, 70%; Singapore, 67%) to be at least 50% relevant or suitable to their own population but would be modified for use with non-Caucasian ethnic groups. For a full listing on statements by all participating MHPs on the "Relevance of Western Therapy Models to Population", see Appendix L.

If Western therapy models were suitable for clients, then it was expected that clients' preference for same gender or ethnic therapist would be infrequently requested. Table 7.24 shows that 36% of New Zealand MHPs and 23% of Singapore MHPs reported client's request for same gender or ethnic therapist that had occurred at least

50% of practice time. Of these requests, the frequencies for clients' personal preference were low (New Zealand, 19%; Singapore, 10%). Forty-five percent of Singapore MHPs did not indicate client's reasons for their requests compared with 25% from New Zealand MHPs who did not do so. Excerpts from statements made by MHPs of both countries on "Clients' Reasons for Request for same Gender/Ethnic Therapist" are given below (see Appendix M for a full listing of the statements made by all participating MHPs).

Statements on "Clients' Reasons for Request for same Gender/Ethnic Therapist" by:	
New Zealand MHPs	Singapore MHPs
Cultural/Language issues	
• Ethnicity - belief that therapist will have greater understanding of contextual issues. • Language/pronunciation/dialectal problems.	• Clients feel that understanding of presenting concerns can best be facilitated if therapist shares similar sociocultural background. • Generally linguistic issues have more bearing on their preferences than ethnic.
Client's personal preference	
• Gender issues. • Lesbian/gay issues - prefer same sexuality; Māori /Pacific Islanders may prefer their own.	• Clients believe that therapists of the same gender would be able to understand their problems better. • Hope to hear views they think would be more balanced.
Comfort/Safety	
• Increased level of comfort and understanding. • Personal comfort; trust; past trauma (sexual).	• Client feels that he/she would be more comfortable and would be able to disclose more and less inhibitions. • Level of comfort for self-disclosure. Initial distrust that therapist might not understand with gender & cultural nuances.
Problem-based	
• Clients may have history of sexual abuse or other negative experiences with a particular gender. • Gender/Abuse issues, power issues.	• Clients' discomfort in discussing sexual disorder. • When it is related to marital, sexual, or abusive issues.
Organisation	
• We have our own way of doing things"	• Being primarily school-based, I think the students/clients may not realise they have any options here!

Other concerns	
• Males want female therapists. • Often also encounter people who do not want same ethnic group mental health worker.	• Some are Christians, Buddhists, or Muslims—deal with appropriately. • Some clients e.g. in army hoping for more "lenient" Dr.
Combination of above	
• Males wanting female therapists; Gays wanting gay therapist; same ethnicity therapist e.g. Māori clients wanting Māori therapists. • Service offered Asian counsellors; language difficulties.	• Clients are more comfortable speaking to a therapist of the same gender. Clients also hope therapist's ethnicity and gender would help him/her to understand clients better. • Clients comfort level, nature of presenting problem.

Thus, similarities in characteristics of MHPs of both countries were found in use of Western therapy models and interventions, relevance of therapy models and gender/ethnic match. Differences between them were found in preferences of therapy models. Hence, data provide support to the hypothesis that the application of Western therapy models in New Zealand and Singapore with non-Westerners entailed some form of modification, and that the number of clients' requests for therapist-client gender or ethnic match was low.

Hypothesis 4 (Diagnostic System)

It was hypothesised that the presenting mental disorders of New Zealand and Singapore clients would be classified and diagnosed as per the Western therapy model and system. Related data are presented in two tables for ease of presentation. Table 7.25 shows the practice characteristics of participating MHPs of both countries with respect to diagnostic system and use of assessment procedures. Table 7.26 shows their practice characteristics with respect to clients seen, clients' presenting problems, and average number of sessions per client.

Table 7.25
Practice Characteristics (Diagnostic System and Assessment Procedures) of New Zealand and Singapore Mental Health Practitioners (combined results)

	New Zealand MHPs (N = 53)	Singapore MHPs (N = 73)
Diagnostic system used		
Use of DSM IV	44 (83.0%)	35 (47.9%)
Use of ICD 10	-	6 (8.2%)
Others	1 (1.9%)	7 (9.6%)
Combination of above	3 (5.7%)	1 (8.3%)
Undisclosed	5 (9.4%)	24 (32.9%)
Frequency of use of assessment procedures ≥50% of time in practice[a, b]		
Wechsler Scales	20 (37.7%)	15 (20.5%)
Depression/Anxiety Scales	29 (54.7%)	19 (26.0%)
Use of assessment procedures as observed[b, c]		
Wechsler Scales	2 (16.7%)	5 (41.7%)
Depression/Anxiety Scales	10 (83.3%)	1 (8.3%)

Note. All percentages are rounded off to one decimal place; hence the total percentage in each column may not be 100.
[a]Participants were asked to indicate frequency of use between 0-100% of time. Only frequencies of significance are tabled here. [b]Multiple endorsements are allowed; hence total percentage of column may add up to more than 100. [c]Participants indicated usage without frequencies in their verbal responses during the interview.

As shown in Table 7.25, 83% New Zealand MHPs compared with 48% of Singapore MHPs had higher use of the DSM IV. Thirty-three percent of New Zealand MHPs did not reveal their use of diagnostic system compared to 9% of Singapore MHPs who did not do so. The reasons offered by some MHPs were that the use of a diagnostic system was unnecessary, it was a requirement of the organisation they worked in, or they would rather discuss directly the client's presenting problem. Excerpts from statements made by MHPs of both countries on "Diagnostic Systems" are given below (see Appendix N for a full listing of the statements made by all participating MHPs).

Sample of Statements on "Diagnostic Systems" by:	
New Zealand MHPs	Singapore MHPs
DSM IV	
• A guide to client's problem. • Because it pathologises, rather interested in client's case/details. • Common language for professionals; saves time and description; ease of referral. • Framework by which to understand client. • Limitation with children; rather behaviour problems. • Quite useful as a tool. • System requires it to be done. • Usually psychiatrists diagnose with DSM; routine use by psychiatrists.	• Diagnosis done before treatment/seen by practitioners, i.e. done by psychiatrists or referred cases to psychiatrists to diagnose. • DSM IV is widely used. • Find it labelling. • Preferred assessment/case formulation method/ see client's problem and have conference/analysis. • Use because psychiatrists/doctors use them. As I conduct more counselling/psycho-educational training in my line of work, my assessment-tools are quite often less DSM IV-based.
Assessment procedures	
• Appropriate to client level/disorder. • Clinical useful though are American and Australian. • Gain additional information on clients. • Limitation of tools, rather interpret results. • Not to use whole assessment on psychometrics; or confront client with stacks of papers rather for homework. • Send client away with questionnaires to save time. • Use cultural/language appropriate versions of tests/scales for specific clients e.g. Chinese.	• Find them helpful to explain facts, clarify diagnosis. • Find them labelling. • Scales are easy ones to understand by clients. • Modified them for use. • Rather collect information from client through sessions. • Tools are Western. • Use own checklists.

Two assessment procedures identified by MHPs from both countries that were used at least 50% of practice time were: the Wechsler Scales (New Zealand, 38%; Singapore, 21%) and the depression/anxiety scales (e.g. Beck's Inventories) (New Zealand, 55%; Singapore, 26%). If observations from the interview samples were included (row 3 of Table 7.25), usage for the depression/anxiety scales would be much higher (up to 74%). For a full listing of the "Frequency of Assessment Procedures in Use" by all participating MHPs, see Appendix O.

As shown in Table 7.26, the clients seen in 2001 by MHPs of both countries were different ethnically and in numbers but not representative of their population ratio. Mainly Caucasian clients were seen by 79% of New Zealand MHPs, fewer Chinese clients by 32% of New Zealand MHPs, fewer Māori clients by 72% of New Zealand

MHPs, and fewer Pacific Island peoples' clients by 45% of New Zealand MHPs. Mainly Chinese clients were seen by 84% of Singapore MHPs, fewer Caucasian clients by 32% of them, fewer Indian clients by 73% of them, and fewer Malay clients by 66% of them. For New Zealand, over-representation was seen among Māori and Pacific Island peoples, whereas for Singapore, over-representation was seen among Indians and Malays. For a full listing of the "Clients seen in Practice in 2001" by all participating MHPs, see Appendix P.

Table 7.26
Practice Characteristics (Client and Caseload) of New Zealand and Singapore Mental Health Practitioners (combined results)

		New Zealand MHPs (N = 53)	Singapore MHPs (N = 73)
Frequency of clients seen in total practice time in 2001[a, b] (with % of time in [])			
Caucasian	[≤ 30%]	-	23 (31.5%)
	[≥ 40%]	42 (79.2%)	2 (2.7%)
Chinese	[≤ 30%]	17 (32.1%)	5 (6.8%)
	[≥ 40%]	2 (3.8%)	61 (83.6%)
Indians	[≤ 30%]	13 (24.5%)	53 (72.6%)
Japanese	[≤ 10%]	4 (7.5%)	6 (8.2%)
Koreans	[≤ 10%]	2 (3.8%)	2 (2.7%)
Malays	[≤ 50%]	1 (1.9%)	48 (65.8%)
Māori	[≤ 50%]	38 (71.7%)	1 (1.4%)
Pacific Island peoples	[≤ 30%]	24 (45.3%)	4 (5.5%)
Client presenting problems seen in practice ≤50% of time[a, b]			
Anxiety		24 (45.3%)	31 (42.5%)
Behavioural problems		18 (34.0%)	32 (43.8%)
Generalised Anxiety Disorder		17 (32.1%)	20 (27.4%)
Major Depression		24 (45.3%)	30 (41.1%)
Marital problems		25 (47.2%)	32 (43.8%)
Client presenting problems seen in practice ≤30% of time[a, b]			
Alcohol Abuse		17 (32.1%)	21 (28.8%)
Attention Deficit Disorder		15 (28.3%)	20 (27.4%)
Eating disorder		22 (41.5%)	14 (19.2%)
Personality Problems		20 (37.7%)	24 (32.9%)
Schizophrenia		10 (18.9%)	14 (19.2%)
Substance Abuse		15 (28.3%)	17 (23.3%)
Client presenting problems seen in practice ≤20% of time[a, b]			
Bipolar Disorder		19 (35.8%)	11 (15.1%)
Obsessive-compulsive Disorder		20 (37.7%)	17 (23.3%)
Panic Disorder		20 (37.7%)	12 (16.4%)
Phobia		17 (32.1%)	12 (16.4%)

Table 7.26 (continued)

	New Zealand MHPs (N = 53)	Singapore MHPs (N = 73)
Client presenting problems as observed[c]		
Anxiety	9 (75.0%)	3 (25.0%)
Attention Deficit Disorder	2 (16.7%)	1 (8.3%)
Behavioural problems	3 (25.0%)	5 (41.7%)
Eating disorder	2 (16.7%)	1 (8.3%)
Major Depression	9 (75.0%)	6 (50.0%)
Marital problems	3 (25.0%)	1 (8.3%)
Obsessive-compulsive Disorder	1 (8.3%)	-
Panic Disorder	1 (8.3%)	-
Personality Problems	1 (8.3%)	-
Phobia	-	1 (8.3%)
Schizophrenia	-	1 (8.3%)
Substance Abuse	-	1 (8.3%)
Clients' problems outlined by 1 country only		
Financial problems	-	4 (5.5%)
Parenting issues	-	5 (6.8%)
Sexual abuse and related PTSD	12 (22.6%)	-
Average number of sessions per client in 2001		
≤ 5	10 (18.9%)	23 (31.5%)
6-10	11 (20.8%)	24 (32.9%)
≥ 11	18 (34.0%)	7 (9.6%)
Undisclosed	14 (26.4%)	19 (26.0%)

Note. All percentages are rounded off to one decimal place; hence the total percentage in each column may not be 100.
[a]Participants were asked to indicate frequency of use between 0-100% of time. Only frequencies of significance are tabled here. [b]Multiple endorsements are allowed; hence total percentage may add up to more than 100. [c]This list of clients' presenting problem is taken from those implied, without frequencies, by participating MHPs in the structured interview (N = 12 for both countries).

The most frequently presented problems identified by MHPs of both countries (in at least 50% of practice time) were anxiety, behaviour problems (e.g. school refusal, conduct problem), generalised anxiety disorder, major depression and marital problems. Next frequently presented problems (in at least 30% of practice time) were alcohol abuse, attention deficit disorder, eating disorder, personality problems, schizophrenia, and substance abuse. If observations from the interview samples were included (row 5 of Table 7.26), the frequencies of clients' presenting problems would be much higher.

Taken together, clients' presenting problems seen by MHPs of both countries were classified as per DSM IV categories. However, as mentioned earlier, there were

clients' problems reported unilaterally occurring in one country only. Reported only by New Zealand MHPs (23%) were sexual abuse and related post-traumatic stress disorder, whereas reported only by Singapore MHPs (6% and 7% respectively) were financial problems and parenting issues. For a full listing of "Presenting Problems of Clients seen in Practice in 2001" by all participating MHPs, see Appendix Q. In addition, the types and problems of clients were seen according to the types and location of services provided.

On the average number of session per client, and with data collapsed into two categories (10 sessions or less, and 11 sessions or more), 40% of New Zealand MHPs compared with 64% of Singapore MHPs had an average of 10 sessions or less per client (there was no significant difference between the groups, $\chi 2 = 2.34$, [df =1, $p \leq 0.20$]), whereas 34% of New Zealand MHPs compared with 10% of Singapore MHPs had an average of 11 sessions or more per client (there was significant difference between the groups, $\chi 2 = 7.51$, [df =1, $p \leq 0.01$]). In other words, New Zealand MHPs had more therapy sessions with their clients than Singapore MHPs had with theirs. Twenty-six percent of MHPs each from both countries did not reveal their data on this item. Some of the reasons MHPs gave for this were: that different therapy approaches were used on clients; and due to the variety of presenting problems seen in practice, different problem required different lengths of treatment.

Thus, similarities in characteristics of MHPs of both countries were found in diagnostic system and use of assessment procedures, clients seen, and clients' presenting problems. Differences between them were found in average number of sessions per client. Nevertheless, data support the hypothesis that the presenting mental

disorders of New Zealand and Singapore clients were classified and diagnosed as per the Western therapy model and system.

Hypothesis 5 (Therapist Self-disclosure)

It was hypothesised that indigenous people and Asian clients would ask their therapists more personal questions, and that this would occur more often with MHPs in Singapore than would be with MHPs in New Zealand given the composition and nature of Singaporeans. It was further hypothesised that, since self-disclosure was not a practice in therapy and professional boundary was duly observed during therapy sessions, New Zealand MHPs would need to self-disclose less or were less accepting of self-disclosure than Singapore MHPs. Table 7.27 shows the practice characteristics of participating New Zealand and Singapore MHPs with respect to experiential skills in handling of self-disclosure. On this issue, 76% of New Zealand MHPs agreed to have some or minimal self-disclosure in session compared with 60% of Singapore who would do so.

Table 7.27
Practice Characteristics (Experiential Skills in handling Self-disclosure) of New Zealand and Singapore Mental Health Practitioners (combined results)

	New Zealand MHPs (N = 53)	Singapore MHPs (N= 73)
Therapist self-disclosure in session		
Accepting some self-disclosure	40 (75.5%)	44 (60.3%)
Not agreeable	2 (3.8%)	2 (2.7%)
Other concerns	2 (3.8%)	1 (1.4%)
Undisclosed	9 (17.0%)	26 (35.6%)

Note. All percentages are rounded off to one decimal place; hence the total percentage in each column may not be 100.

Seventeen percent of New Zealand MHPs compared with 36% of Singapore MHPs did not reveal their data on this item. One pertinent reason given by MHPs was

that it had not occurred in their therapy sessions. Excerpts from statements made by MHPs of both countries on "Handling of Self-Disclosure" are given below (see Appendix R for a full listing of the statements made by all participating MHPs). Details on themes made by these MHPs on this issue have been discussed in Part II of the study.

Sample of Statements on "Handling of Self-disclosure" by:	
New Zealand MHPs	Singapore MHPs
Accepting some self-disclosure	
• A bit, limited, to put client at ease. • Am happy to make self-disclosure to an appropriate level if beneficial to the therapeutic process. • Because dealing with young people, push boundary a bit; prepared to share a bit, because innermost stuff of theirs. • Depends on clients' issues/profile and stage of therapy. • Limit self-disclosure to what is relevant to the client/counsellor relationship. • Not with mainstream clients; but with Chinese clients because important to do some self-disclosure to build rapport faster, has therapeutic effect too. • Occasional anecdotes if relevant to client issues. • Quite frequently; tell enough to be polite, build rapport as well. • Self-disclosure if useful, use own examples to explain point or gain rapport, because client share personal information; break rules with teenagers, make it comfortable for person. • Self-disclosure to join with people, normalise difficulties of theirs. • Use in small doses when appropriate, with certain clients to illustrate a pertinent point. • When necessary – e.g. at opening of sessions with Maori clients.	• As and when necessary during the therapy process or when clients ask. • Can be done but with limits and on certain patients who do not have problems with boundaries and limit setting. • Certain amount of self-disclosure is at times useful for the therapeutic relationship to work well. • If it is helpful for client, e.g. to normalise his/her experiences. As well as depending on what and when to disclose, this therapist will have a boundary. • I'll use it only when appropriate -- when it provides insights into clients' thoughts, feelings and experiences. • No problem. Self-disclosure is made to relate/empathise with clients' current or future concerns. • Not a problem when appropriate. Use it enough times. • Sharing of personal info is dependent on: appropriateness to context of client's situation and asking what client has gleaned from such sharing. • Tend to do it indirectly, rather than disclosing it as a 1st person. But with teenagers, do tend to share more personal experiences. • When appropriate, especially to normalize certain emotions or thoughts.
Not agreeable	
• Make clear professional boundaries. • With strict confidentially, except for exceptions indicated in the Psych Code of Ethics. • Stick to interpretation of therapy; client preferred practitioner to speak from academic or practical knowledge; would ask client the relevance of personal question.	• Limited to professional information. • Refrain from this. • Set clear boundaries & do not like to self-disclose. • Strictly confidential.
Other concerns	
• Receptive - reflective, E.M.D.R probe.	• Seldom used.

Thus, similarities in characteristics of MHPs of both countries were found in experiential skills in handling of self-disclosure. No differences between them were found. The hypothesis is not supported by data from this study.

Hypothesis 6 (Religious or Spiritual Issues)

It was hypothesised that MHPs of both New Zealand and Singapore would frequently face religious or spiritual issues brought up by clients in therapy, especially from proselytes, or those who have found them helpful in coping with their life issues. Table 7.28 shows the practice characteristics of participating New Zealand and Singapore MHPs with respect to experiential skills in handling of religious or spiritual issues. On this issue, 81% of New Zealand MHPs and 67% of Singapore MHPs agreed to discuss clients' religious or spiritual in session and refer on to a person of religious qualification to handle if they found the case inappropriate for therapy.

Table 7.28
Practice Characteristics (Experiential Skills in handling Religious/Spiritual Issues) of New Zealand and Singapore Mental Health Practitioners (combined results)

	New Zealand MHPs (N = 53)	Singapore MHPs (N = 73)
Religious/Spiritual Issues		
Discuss religious/spiritual issues and refer on	43 (81.1%)	49 (67.1%)
Not agreeable	-	2 (2.7%)
Other concerns	3 (5.7%)	5 (6.8%)
Undisclosed	7 (13.2%)	17 (23.3%)

Note. All percentages are rounded off to one decimal place; hence the total percentage in each column may not be 100.

Thirteen percent of New Zealand MHPs compared with 23% of Singapore MHPs did not reveal their data on this item. One pertinent reason given by MHPs was that it had not occurred in their therapy sessions. Excerpts from statements made by

MHPs of both countries on "Handling of Religious or Spiritual Issues" are given below (see Appendix S for a full listing of the statements made by all participating MHPs). Details on themes made by these MHPs on this issue have been discussed in Part II of the study.

Sample of Statements on "Handling of Religious or Spiritual Issues" by:	
New Zealand MHPs	Singapore MHPs
Discuss religious or spiritual issues and refer on	
• Acceptable - good for client to involve their supports and faith. • Understand how they fit with person; part of person. • Its' within family; a process; part of family. • Another dimension; another tool to assist problem solving. • Complement therapy; conjunction to therapy. • Clarify what I can do and what I can't. Respect observances such as prayer and sometimes contribute prayer. • Even if religion is different from practitioner's, practitioner still wants to understand client's problem, symptoms; what strength drawn from the religion. • May incorporate if client is of same religion as therapist. • Would have (in) session with family to pray before and after session. • I explore those issues in therapy. If necessary, suggest my client make contact with an appropriate religious leader/guide in the community.	• Accommodate it, welcome it, process it with them. • Assume a neutral position or adopt a seek to understand his worldview to clients who are either having similar or different religious affiliation. • Complements therapy. • I welcome such issues in part of its usefulness to client as coping-resource and what client learns about self in the discussion of such issues. • If same religion, use Bible. If does not contradict Christianity. • I'll use it when it holds meaning for clients, and when it can be harnessed as a source of strength and support. • Religion is one approach to solving problems. • Spirituality is important; man incomplete without it; is beyond therapy. • Will discuss with them about their religious inclinations and the role it plays in their lives. May even use it as leverage in motivation. • Refer clients to a church pastor. Network closely with church pastor in the intervention process.
Not agreeable	
•	• Beliefs obstruct discussion; though it is part of culture, and neutral to therapy. • Try not to involve religion.
Other concerns	
• Intervene if religious person stops client taking medication.	• Muslim patients generally ask the therapist early in therapy if I am a Muslim. They prefer to not discuss religious issues.

Thus, similarities in characteristics of MHPs of both countries were found in experiential skills in handling of religious or spiritual issues. No differences between them were found. The hypothesis is supported by data from this study.

Hypothesis 7 (Traditional Healing Practices)

It was hypothesised that as MHPs of both New Zealand and Singapore have been trained in Western psychology and therapy, they were likely not to accept the traditional healing practices of their clients while undergoing therapy, or would like them to be kept separate from therapy if clients would insist on continuing with those services. Table 7.29 shows the practice characteristics of participating New Zealand and Singapore MHPs with respect to experiential skills in handling of traditional healers. On this issue, 66% of both New Zealand and Singapore MHPs had no objection to the use of traditional healing services by clients. Of these, 45% of New Zealand MHPs and 21% of Singapore MHPs would allow them to work alongside them in therapy.

Table 7.29
Practice Characteristics (Experiential Skills in handling Traditional Healers) of New Zealand and Singapore Mental Health Practitioners (combined results)

	New Zealand MHPs (N = 53)	Singapore MHPs (N = 73)
Traditional healers		
No objection to services	35 (66.0%)	48 (65.8%)
Objection to services	3 (5.7%)	7 (9.6%)
Undisclosed	15 (28.3%)	18 (24.7%)
Allowing them alongside in therapy[a]	24 (45.3%)	15 (20.5%)
Not allowing	9 (17.0%)	27 (37.0%)
Undisclosed	20 (37.7%)	31 (42.5%)

Note. All percentages are rounded off to one decimal place; hence the total percentage in each column may not be 100.
[a]Based on the responses of "no objection to services" to traditional healers.

Thirty-eight percent of New Zealand MHPs and 43% of Singapore MHPs did not reveal their data on this item. One pertinent reason given by MHPs was that it had not occurred in their therapy sessions. Excerpts from statements made by MHPs of both countries on "Handling of Traditional Healers" are given below (see Appendix T for a

full listing of the statements made by all participating MHPs). Details on themes made by these MHPs on this issue have been discussed in Part II of the study.

Sample of Statements on "Handling of Traditional Healers" by:	
New Zealand MHPs	Singapore MHPs
Acceptance of services	
• At client's request. • Client may them more often than once/week therapy e.g. pastor, monks. • For allowing traditional healer to work alongside, I would want to keep informed. If appropriate. • Have done that with pastors/ministers; pleasant, helpful to the individual. • Important to client; but keep separate. • May discuss first in group with client and traditional healer; no one talks above client. • Respect them; work with family; family's choice. • They can see them separately and consult/liaise with me. • Would be part of treatment planning and agreed by client, caregiver & traditional healer.	• As a tool. • As long as no contraindication/interference • Client came in with priest, prayed with family, (Muslim). • Different working styles. Usually I accede to family's request to involve a traditional healer to on to have a rapport with the family. • I encourage them to seek alternative treatment but only before or after psychotherapy, but not during treatment as it. • I welcome other forms of intervention that client deems appropriate and useful for his/her progress. • No objection based on respect of client's cultural/belief/value system. • Would analyse views of traditional healer with client; may have case conference.
Objection to services	
• Have some hesitation; though some may help; beware of psychosomatic problems.	• However, therapist finds it will be difficult to work with someone who shares different beliefs of health. • The therapeutic goals/approaches may be different of even conflict with each other.
Other concerns	
• I would want to be educated about the practices, aims and outcomes. • My organization would most probably not support this.	• Be careful of their use. • Organization does not have such a system in place.

Thus, similarities in characteristics of MHPs of both countries were found in experiential skills in handling of traditional healers. No differences between them were found. The hypothesis is not supported by data from this study.

Summary

A summary of all the hypotheses in relation to the outcome of this study is made here. First, the hypothesis that therapist characteristics of both New Zealand and

Singapore MHPs should reflect characteristics of the mental health care and services of their respective country was partially supported by data on gender, ethnicity, language ability, and focus of practice. Secondly, the hypothesis that MHPs of both New Zealand and Singapore had been trained in Western psychology and therapy, and that New Zealand was well established in clinical psychology was supported by relevant data. Thirdly, the hypothesis that the application of Western therapy models in New Zealand and Singapore with non-Westerners entailed some form of modification, and that the number of clients' requests for therapist-client gender or ethnic match was low, was supported by relevant data. Fourthly, the hypothesis that presenting mental disorders of New Zealand and Singapore clients were classified and diagnosed as per the Western therapy model and system was supported by relevant data. Fifthly, the hypothesis that indigenous people and Asian clients would ask their therapists more personal questions particularly with Singapore MHPs, and that New Zealand MHPs would need to self-disclose less or were less accepting of self-disclosure, was not supported by relevant data. Sixthly, the hypothesis that MHPs of both countries would frequently face religious or spiritual issues brought up by clients in therapy was supported by relevant data. Lastly, the hypothesis that MHPs of both countries were trained in Western therapy, and would not likely to accept the traditional healing practices of their clients and would like them to be kept separate from therapy, was not supported by relevant data.

CHAPTER 8

DISCUSSION

This chapter discusses similarities and differences in characteristics, self-reported practices and experiential skills between New Zealand and Singapore MHPs obtained from the overall results of the study. Implications for use of Western therapy with Chinese clients are further discussed, as well, for CBT. At the end of the chapter, limitations of the study and recommendations for future research are highlighted before the conclusion.

Similarities between MHPs of both New Zealand and Singapore are divided into 4 categories:

(1) Similarities in personal and demographic characteristics with respect to gender, ethnicity, and language ability.

(2) Similarities in professional characteristics with respect to country of therapy training, qualification in therapy, number of years of supervised training received, and use of Western therapy models and interventions.

(3) Similarities in practice characteristics with respect to relevance of therapy models, focus of practice, diagnostic system and use of assessment procedures, clients seen, and clients' presenting problems, gender/ethnic match.

(4) Similarities in experiential skills with respect to handling of self-disclosure, religious or spiritual issues, and traditional healers.

Differences between MHPs of both New Zealand and Singapore are divided into 3 categories:

(1) Differences in personal and demographic characteristics with respect to age range and religious affiliation.

(2) Differences in professional characteristics with respect to primary job affiliation, availability of clinical psychology programmes, years of experience in therapy, and registration of practice.

(3) Differences in practice characteristics with respect to preferences of therapy models, and average number of sessions per client.

Similarities in Personal and Demographic Characteristics

The hypothesis that personal, professional and practice characteristics of New Zealand and Singapore MHPs would be representative of their characteristics in their respective country was partially supported by the following data.

The higher number of responses received from female than from male MHPs was not a coincidence. The same occurrence was found in the samples of a number of other studies---counsellors in Britain (Hollanders & McLeod, 1999); psychotherapists in Korea (Bae, Joo, & Orlinsky, 2003); MHPs in New Zealand (Johnstone, 1997; Kazantzis & Deane, 1998; Maidment, 2000; Patchett-Anderson, 1997; Tassell, 2004); counsellors in the United States (Young, 1993); psychotherapists in the United States (Katz, Juni, & Matz, 2003); MHPs in 8 European countries (Tantam, van Deurzen, & Osterloh, 2001); and MHPs in 12 countries across Europe and North America (Orlinsky, Ambühl, Rønnestad, Davis, Gerin, & Davis, et al., 1999).

In particular, the study by Kazantzis & Deane (1998) acknowledged that the occurrence was consistent with the total population of clinical psychologists in New Zealand, which undoubtedly had more female members. Although official publication on the gender ratio was not available for Singapore MHPs, two studies might imply female preferences for working in counselling and psychotherapy services there. A

study by Ang, Lim, and Tan (2004) found that female Singaporeans, compared with males, had more positive attitudes toward professional help seeking, and were more willing to recognise a personal need for professional help. In another study by Ng and Chan (2000), female students scored higher on the attitude of benevolence (defined as a kindly orientation towards people with mental illness) than male students who were stereotyping and stigmatising towards mental illness. If sample bias were not the reason for the occurrence, then many countries might actually have more female MHPs than male MHPs. This finding requires further investigation.

The representative ratio of the ethnicity of MHPs to their respective population for both countries obtained in this study assures a balance in the provision of mental health carers to clients. The representative ratio of ethnicity of New Zealand MHPs to population is apparent from the list of registered clinical psychologists purchased. A study by Patchett-Anderson (1997) affirmed that most clinical psychologists in New Zealand were Caucasian. The only source of information on ethnic ratio of MHPs in Singapore comes from the list of registered psychiatrists (Singapore Medical Association, 2003) in which Chinese members predominate with the presence of a few Indian members. Comparatively, in the United Kingdom, there were more psychoanalytic and psychodynamic psychotherapists than any other MHPs (Jacobs, 2000). In the series of studies by the Collaborative Research Network of the Society for Psychotherapy Research, psychologists and psychiatrists were typically among the largest groups of MHPs in most countries (Orlinsky & Ronnestad, 2005).

English was noted as the main language used in therapy sessions by MHPs from both countries, and other languages or dialects were used for non-English speaking clients. Notably, jargon, nuances and personal meanings in the use of English (Wong, Ishiyama, & Wong, 1999) by native speakers like New Zealanders and non-native

speakers like Singaporeans might show up in therapy. This would constitute an interesting investigation on the impact of language of non-native English speaking clients in Western therapy conducted by Western therapists.

Notably, with Asians in New Zealand, interpreters were frequently called upon to assist in "interpretation" in session. New Zealand MHPs in this study (see Appendix L) have commented that this service was not problem-free; for example, interpreters might not "interpret" verbatim, instead summarised what the client said, or had added their words into the interpretation. Nevertheless, this concern was included in the recent forums of the Asian Cross-cultural Interest Group in New Zealand (S. Wong, personal communication, March 1, 2006). Perhaps, in this service, verbal translator is the more appropriate term to use than interpreter. The difference between an interpreter and a translator has been made by New Zealand's Office of Ethnic Affairs (Department of Internal Affairs, 2006). Accordingly, an interpreter's role is to render orally the meaning of the spoken word from one language into another language, and must interpret everything the client has said, even if it seems silly or embarrassing, whereas, a translator writes or transcribes the message from one language into the other language (Department of Internal Affairs, 2006).

Similarities in Professional Characteristics

The hypothesis that MHPs of both New Zealand and Singapore had been trained in Western psychology and therapy, and that New Zealand was well established in clinical psychology was supported by the following data.

MHPs from New Zealand and Singapore were found to be formally trained in Western psychology and therapy at the universities worldwide with an average of 2 to 3

years of supervision in training. A research by Kee (2004) has verified that MHPs in Singapore were trained in Western therapy models either through an overseas education or through local training programmes conducted by Western or Western-trained professionals. Together with registration for practice, formal training and qualification would make counselling and psychotherapy services even more recognized for their people. Despite these establishments, MHPs in both countries are wary of non-accredited training offered in short therapy or weekend courses that claimed effectiveness in treatment of mental disorders.

Western therapy models and interventions were adopted for use in New Zealand on the basis of empirical status as well as links with Western culture; perhaps, partly spurred on by the absence of formal indigenous therapy models. For Singapore, they were adopted mainly because of Westernisation and spurred on by the absence of formal indigenous therapy models. [Note that some researchers have considered traditional healing practices of non-Caucasian ethnic groups, like Māori and Chinese, indigenous therapy models (e.g., Lee, 2002; Love, 1999).] However, they were modified by the MHPs for use with non-Caucasian ethnic groups. This view is upheld by many researchers on the use of Western individual psychosocial approaches on non-Western clients (e.g., Culbertson, 2001). A survey by Ang (2001) verified that the majority of Singapore MHPs viewed psychotherapy as cost-effective, and only to be disrupted if psychotic symptoms became apparent in the client.

Among the range of Western therapy models, the cognitive behaviour model was most used by New Zealand and Singapore MHPs followed by the eclectic/integrative model. A study by Patchett-Anderson (1997) ascertained that over half of New Zealand clinical psychologists practised from a cognitive-behavioural orientation. A study by Kazantzis & Deane (1998) had found that a third of New

Zealand psychologists identified with the eclectic orientation, with CBT as the main approach used. Ang (2001) alluded that Singapore psychiatrists were likely trained in psychodynamic psychotherapy and CBT, counsellors in client-centred therapy, psychologists in CBT, and social workers in systemic therapy.

Comparatively, a study by Orlinsky, Ambühl, Rønnestad, Davis, Gerin, and Davis, et al. (1999) found mainly eclectic and psychoanalytic/ psychodynamic therapy orientations among psychotherapists in 12 countries of Europe and North America. A survey by Bae, Joo, and Orlinsky (2003) found therapy orientations specific among Korean MHPs: counsellors were predominantly humanistic, psychologists were cognitive, psychiatrists were analytic/psychodynamic, and social workers were eclectic—systemically oriented, humanistic and analytic/ psychodynamic. Young's (1993) survey found that American counsellors had a strong preference for eclecticism, with heavy influence by the person-centred theory of Carl Rogers. A survey of American psychologists by Norcross, Hedges and Castle (2002) found that they were more eclectic/integrative in therapy orientations, and less into the psychodynamic and cognitive orientations. Yet another survey by McClure, Livingston, Livingston, and Gage (2005) found that the most popular therapeutic orientation was eclecticism, followed by cognitive-behavioural, among practising psychologists and counsellors in Texas, United States. A study by Hollanders and McLeod (1999) showed that most counsellors in Britain held an eclectic/integrative therapy orientation.

It seems that the eclectic orientation is becoming the choice for MHPs worldwide. Notably, there is a difference between eclectic and integrative therapy orientations. Broadly defined, eclectic psychotherapy indicates non-adherence to a single viewpoint (Young, 1993). It implies selecting the best from many theoretical stances. Integration psychotherapy is concerned with using and combining the most

effective elements of psychotherapy theory and practice to help a wider range of clients with a broader spectrum of problems (Gold, 2002). The three most commonly discussed forms of integration are technical eclecticism, the common factors approach, and theoretical integration (Gold, 2002; Young, 1993).

Based on observations of MHPs who subscribe to the eclectic orientation, it is hypothesised that this occurred as a result of being trained in various therapy models, having accumulated years in therapy experience, and having conducted therapy with multicultural clients. In other words, an eclectic therapist would have, in his or her repertoire, choices of therapy approaches to better suit the individual client's needs. Perhaps in the near future, the development of therapy in Asia would shift towards integrated models. Already, Lee (2002) had used so-called indigenous Chinese psychotherapies with CBT on his patients, and Chua (2003) had used Buddhist spiritual beliefs in family therapy with an Asian family. In the recent Asian CBT conference (Foo, Merrick, Kazantzis, & Williams, 2006), MHPs from China, Hong Kong, India, Japan, Korea, Malaysia, Philippines, Singapore and Thailand have included Buddhism, positive psychology, and indigenous practices in their therapy treatment of their clientele.

With regard to therapy interventions, a study by Patchett-Anderson (1997) demonstrated that cognitive and behaviour interventions were most used by New Zealand clinical psychologists. A survey by Tassell (2004) of Māori mental health workforce in 2002 found equal use of cognitive, family and narrative therapies by them. A study of Singapore MHPs by Ang (2001) that psychiatrists were likely trained in psychodynamic psychotherapy and CBT, counsellors in client-centred therapy, psychologists in CBT, and social workers in systemic therapy was not supported by results of this study. Comparatively, a study by Hollanders and McLeod (1999) showed

that cognitive change techniques were the next frequently used intervention after emphatic reflecting by counsellors in Britain. Apparently, there had been a general shift from behavioural towards cognitive and short-term interventions by British nurse therapists, perhaps, with other MHPs as well (Newell & Gournay, 1994). Zerbetto and Tantam (2001) found that psychodynamic, systemic family, Gestalt and cognitive-behaviour therapies were used mainly in 31 European countries. It seems that CBT is becoming the main therapy approach used by MHPs worldwide. Perhaps, cognitive and behavioural explanations of human mental health problems are better envisioned, theorised and received.

Inconclusive Data

The inference on whether there were more MHPs working in the public or private sectors for both samples is not definite due to the overlap of "employment" and "primary work" data requirements in the questionnaire, and the possible holding of dual offices by MHPs in New Zealand. What is affirmative, however, is the emphasis of the respective government in the provision of mental health services. For instance, the government of New Zealand has de-instutionalised the mental health services. The government of Singapore runs the major mental health hospital, but has restructured other hospitals towards private ownership, and encourages its people to make health care a personal responsibility. The impact of these policies has not been measured whether there will be a rise in the provision of private mental healthcare services. The study by Patchett-Anderson (1997), which showed that the ratio for clinical psychologists working in the public sector as against private practice was about two to one, could not be generalised to all MHPs in New Zealand. Kazantzis and Deane's (1998) study found that 31% of New Zealand psychologists worked in private practice

with the rest in other sectors, whereas Tassell's (2004) survey found that 49% of Māori mental health workforce worked in District Health Boards compared with 38% of them working in non-government organisations.

Notably, in New Zealand, MHPs working in the public sector can simultaneously hold private practice, whereas in Singapore, public MHPs are not allowed to do so. For example, New Zealand MHPs had pointed out that one could be conducting therapy with private clients while carrying out psychological assessments for court cases. The advantage with this is that New Zealand MHPs are in a better position to gauge the overall mental health picture of their clients. The prudence, of course, is not to refer clients from public to private practice. Comparatively, the surveys by Young (1993), and Norcross, Hedges, and Castle (2002) showed that the majority of American counsellors were employed in the private sector; whereas Bae, Joo, and Orlinsky's (2003) survey found that the majority of Korean psychotherapists were in private practice compared with only 11% in the private sector.

Similarities in Practice Characteristics

The hypotheses that the application of Western therapy models in New Zealand and Singapore with non-Westerners entailed some form of modification, that presenting mental disorders of New Zealand and Singapore clients were classified and diagnosed according to the Western therapy model and system, and that the number of clients' requests for therapist-client gender or ethnic match was low, were supported by the following data.

To iterate, Western therapy models and interventions adopted for use in New Zealand and Singapore were rated high by MHPs from both countries (New Zealand,

70%; Singapore, 67%) to be at least 50% relevant or suitable to their own population but would be modified for use with non-Caucasian ethnic groups. A survey by Ang (2001) found that the majority of Singapore MHPs agreed that technique modification was necessary for non-English speaking clients. The rating of at least 50% was the result of averaging out the responses from the MHPs. As Blampied (2001) had contended, averaging group results might not be indicative of overall or individual case results. Important meanings of the results would be lost. From the data of the MHPs in the structured interview, the relevance of Western therapy to Easterners or Asians embraces many factors. Among them are meeting of clients' expectations for therapy, acceptance of their use of traditional healing practices, and the possibility of a cognitive match on mental illness between non-Caucasian clients and therapists. This example supports the use of the mixed design.

MHPs from both countries were treating adult clients more than clients from other age groups. This is expected as mental health facilities in New Zealand and Singapore cater more to the adult population (Ministry of Health, 2004; Yeo, 2004). An earlier study by Kazantzis and Deane (1998) noted specifically that 19% of New Zealand psychologists were providing services to adult mental health, but due to the variety of mental health services offered in New Zealand, the actual percentage could not be determined. Nevertheless, this is also a common phenomenon in most countries that have a higher population of adults. For example, a survey of MHPs by Orlinsky, Ambühl, Rønnestad, Davis, Gerin, and Davis, et al. (1999) in 12 countries of Europe and North America found that nearly all of them were treating adult clients between 20 and 49 years of age. The same was found of the majority of MHPs in Korea in the survey by Bae, Joo, and Orlinsky (2003).

Along with Western therapy models, New Zealand and Singapore MHPs used mainly the DSM diagnostic system and Western assessment procedures. A study by Patchett-Anderson (1997) demonstrated that objective assessments were most used by New Zealand clinical psychologists. MHPs, however, cautioned that the use of diagnostic and assessment procedures might be "labelling" clients though that might save therapy time. Instead, these procedures should serve as guides to the client's problems, and a common language among professionals. The informal clinical interview was still the preferred choice of diagnosis and assessment. Some MHPs had also devised their own assessment checklists for use.

Mental disorders and problems of New Zealand and Singapore clients were identified and classified as per nomenclature of DSM IV, and seen according to types and locations of services offered by their MHPs. There was no indication by MHPs from either country on the use of a different classification or diagnosis system for non-Caucasian clients; rather the MHPs were satisfied with the existing diagnostic criteria of the DSM.

There were, however, three client problems specific to only one country. Reported only by New Zealand MHPs were sexual abuse and related post-traumatic stress disorder, and reported only by Singapore MHPs were financial problems and parenting issues. Given international reports of sexual abuse, it is highly unlikely that there is a total absence of sexual abuse in Singapore. A more likely explanation is that it is not culturally acceptable to more openly disclose that problem area. Similarly, it is highly unlikely that New Zealand MHPs do not have clients who present with financial problems and parenting issues. A more likely reason for the disparity between the two samples is that these problem areas were not specifically listed among the more commonly presenting client problems seen by MHPs, and were reported as additional

problems under the "Other" category of clients presenting problems in the questionnaire. Another probable reason is that the sample size of this study precludes a greater range of presenting clients' problems.

Clients seen by New Zealand and Singapore MHPs in this study were not representative of their country's population ratio. For New Zealand, though over-representation was seen among Māori and Pacific Island clients, under-representation were not seen among Chinese clients as discussed. If this is not due to sample bias, then, perhaps, Chinese New Zealanders are coming forward for help with their mental health problems. For Singapore, over-representation were seen among Malays (a know fact that they had used mental health services more than other ethnic groups; Ng, Fones, & Kua, 2003) but not among Indians as discussed. This perhaps is due to sample bias and needs further investigation.

Consequently, with Western therapy models appraised by MHPs of both countries to be sufficiently effective for New Zealander and Singaporean clients, client's personal request for gender or ethnic match therapist was found infrequent. Perhaps, the cognitive match has prevailed between the MHPs and clients. Evans (2002) suggested that this "match" between MHPs and clients might have found its way in New Zealand due to the cognitive approach adopted by their clinical training programmes, their MHPs not being restricted by a medical or disease model of clients' difficulties, and the strong link between individual and community-oriented programmes. From a different perspective, that may signify a wide acceptance of Western therapy.

Similarities in Experiential Skills

The hypotheses that Singapore MHPs would have to self-disclose more to their clients and that New Zealand MHPs would need to self-disclose to their clients was not supported. The hypothesis that MHPs of both countries would frequently face religious or spiritual issues brought up by clients in therapy was supported. The hypothesis that MHPs of both countries would not likely to accept the traditional healing practices of their clients due to their training in Western therapy was not supported. The following data provide verify these assertions.

A majority of New Zealand and Singapore MHPs in this study reported to have some self-disclosure in session. This involved sharing of professional information, some personal information or experience, and some anecdotes. The main reason for therapist self-disclosure was building rapport with the client for the facilitation of therapy. This is a surprising finding given the principles and philosophy behind Western therapy, which emphasises maintaining professional boundary. Furthermore, this is expected to occur frequently with Singapore MHPs than with New Zealand MHPs given the cultures of clients they work with. It simply shows the concessionary attitude of the MHPs towards cultural issues of clientele.

Self-disclosure by MHPs of other countries, however, falls on more sensitive concerns like race differences. For example, a study by Burkard, Knox, Groen, Perez, and Hess (2006) found that European American psychotherapists self-disclosed their reactions to clients' experiences of racism or oppression, and these helped the clients felt understood about such experiences, and enabled them to move on to other important issues. Another study by Maxie (2002) found that therapists, who had less experience in working with diverse clients, were more likely to discuss in-session issues on ethnic

dissimilarity as an acknowledgement of these issues. A further study by Maxie, Arnold, and Stephenson (2006) found that in addition to having less experienced with diverse clients, therapists who were female, older, non-minority, and viewed training as an important factor, were more likely to have discussions about ethnic dissimilarity. Furthermore, they found that eclectic and cognitive behavioural therapists had fewer discussions about ethnic differences than psychodynamic, psychoanalytic, humanistic and integrative therapists. Therapists and clients, however, were equally likely to initiate discussions. Even though self-disclosure was not usually a topic included in therapy training, these researchers asserted that therapists often described themselves as comfortable with and skilled at these discussions. This was also experienced by the New Zealand and Singapore samples in this study.

A majority of New Zealand and Singapore MHPs would discuss religious or spiritual issues in session at the request of the clients, and refer on to a person of religious qualification to handle if they found the case inappropriate for therapy. The main reason for this agreement was a respect of the client's faith or belief system that would lead to a better understanding of the client. As discussed, given the intertwined relationship among religion, spirituality, and the quest for mental fulfilment, the topic is inevitable in therapy. The therapist would like to understand what religious or spiritual issues would have in relation to the clients' presenting problem. A pertinent remark made by MHPs on these issues was that the therapist did not have to have a similar religion to understand the client. It was akin to not having been an alcoholic but the topic of discussion could still be on alcoholism—a case of vicarious learning. Once again, it shows the MHPs' flexibility towards cultural issues.

Furthermore, a majority of New Zealand and Singapore MHPs had no objection to the use of traditional healing services by clients. Remarkably, despite being trained in

Western therapy, they would allow a traditional healer to work alongside in therapy, and those who had accepted this had found them useful adjuncts to therapy, as what researchers have found. The main reason for accepting traditional healing practices in therapy was a respect of the client's cultural or value system. The caveat was that the therapist would be consulted first. Thus, traditional healing practices cannot be ruled out when treating multicultural clients as they coexist with Western medicine in New Zealand (Culbertson, 2001; Love, 1999) and Singapore (Lee, 2002; Lim & Bishop, 2000), and clients find them useful and beneficial as in symptom relief, reduction of side effects of Western medicine, and leading to a positive attitude and mind. The exception is to look out for dangers like side effects of herbal cures, incorrect attribution to treatment effects, and complication to the therapy process.

Research on traditional healing practices in New Zealand has yet been published, but its importance has been surfacing in forums in the Asian Cross-cultural Interest Group in New Zealand (S. Wong, personal communication, March 1, 2006). The latest topic was about, "Psychiatrist/Traditional Healer: Unwitting Partners, a Challenge for the Development of Mental Health Services". As mentioned, a study by Samion (1999) found that Singapore clients had high confidence in traditional healers, and found them appeasing their needs. Notably, the public psychiatric hospital in Singapore networked with MHPs and traditional healers to help reduce the duration of untreated psychosis, mainly schizophrenia, among patients (Chong, Lee, & Verma, 2004). The networking strategy had gained increased participation by MHPs. In contrast, there was little direct cooperation between traditional healers and the formal health care service in Malaysia, whose mental health development was similar to that of Singapore (Deva, 2004).

On a slightly different context, a study by Yeh, Inman, Kim, and Okubo (2006) found that coping strategies of Asian American relatives of victims of the September 11 attack on the World Trade Centre included use of indigenous healing methods such as fortune-telling, meditation, chi-gong healing, and Chinese medicine. There was also an increase in religious or spiritual activity (e.g., increase in prayer, going to church, speaking with a pastor, attending religious functions). Hence, the reliance on traditional healing practices cannot be ruled out in times of need.

The account of experiential skills of MHPs in New Zealand and Singapore in dealing with cultural-sensitive issues of self-disclosure, religion and spirituality, and traditional healing practices reflects the flexibility of Western-trained therapists in cross-cultural settings. These experiences would be considered sound therapy skills worth emulating. The reservations some MHPs did have about having these issues in therapy are valid too. Interestingly, given the nature of Singaporeans, a higher percentage of Singapore MHPs did not indicate their views on these three issues compared with that from New Zealand MHPs who did not do so. This needs to be further investigated.

Differences in Personal and Demographic Characteristics

The hypothesis that personal, professional and practice characteristics of New Zealand and Singapore MHPs would be representative of their characteristics in their respective country was not supported partially by the following data from this study.

New Zealand's sample of MHPs was generally older (over 41 years of age). Kazantzis and Deane's (1998) study on New Zealand psychologists found that their average age of was 41 years. Tassell's (2004) survey found that 60% of Māori mental

health workforce was in the age group below 40 years. Comparatively, a survey of American counsellors by Young (1993) found that their average age was 45 years. A survey of counsellors and psychologists in Texas by McClure, Livingston, Livingston, and Gage (2005) found that the mean age for counsellors was 48, and for psychologists, 50. Another survey of MHPs by Orlinsky, Ambühl, Rønnestad, Davis, Gerin, and Davis, et al. (1999) found most of the psychotherapists in 12 countries of Europe and North America were between 30 and 50 years of age, with a mean of 41 years.

Conversely, Singapore's sample of MHPs was generally younger (below 40 years of age) Comparatively, a survey of Korean MHPs by Bae, Joo, and Orlinsky, (2003) found that the majority of counsellors, nurse therapists, psychiatrists, and social workers were below 30 years of age, whereas the average age for most psychologists was 37 years. Perhaps, mental health development in New Zealand parallels those of Europe and the United States, and Singapore's matches that of Korea. It may also imply the temporal effects of the spread of Western therapy to the East.

New Zealand MHPs had indicated that their religious affiliation would be kept separate from therapy though they might discuss religious or spiritual issues of their clients. This might explain the low response on their indication on religious affiliation even though New Zealand's population is predominantly Christian. It is interesting to note, however, that despite the predominant religious affiliations of Singaporeans being Buddhism and Taoism (Statistics Singapore, 2006), a majority of the present Singapore sample indicated religious affiliation with Christianity. It is hypothesised that this phenomenon may be due to their Westernised upbringing and English education that Singaporeans have been differentially exposed to. This finding requires further investigation.

Differences in Professional Characteristics

The population New Zealand and Singapore MHPs have as many counsellors as psychologists, but responses from both samples of MHPs obtained were not representative of those. Perhaps, this was a result of sample bias. It may well reflect the difficulty in reaching the desired sample of participants without the availability of official professional listings. Furthermore, the primary job affiliation of MHPs was indeterminable from data on therapist training as MHPs were variously trained in different countries.

New Zealand MHPs have the advantage of being locally trained in the available clinical psychology programmes, whereas Singapore MHPs have to rely on overseas institutions for this form of clinical training. A survey by Ang (2001) found that 70% of Singapore psychiatrists were trained in the United Kingdom, whereas Singapore counsellors, psychologists and social workers were trained in Asia and the United States. Given the demand for counselling and psychotherapy services, perhaps, it is time in Singapore to set up clinical psychology programmes. Advice and assistance could come from clinical psychology instructors in New Zealand.

New Zealand's sample of MHPs had more years of experience in therapy (over 11 years). Kazantzis and Deane's (1998) study found the years of experience of New Zealand psychologists ranged from 1 to 35 years, with a modal number of 20 years. In the series of studies by the Collaborative Research Network of the Society for Psychotherapy Research, most psychotherapists worldwide had 7 to 15 years of experience in therapy (Orlinsky & Ronnestad, 2005). Comparatively, a survey of American counsellors by Young (1993) found that they had a mean of 15 years in therapy experience. A survey of counsellors and psychologists in Texas by McClure,

Livingston, Livingston, and Gage (2005) found that all counsellors and psychologists had over 10 years of experience in therapy.

Conversely, Singapore's sample of MHPs had fewer years of experience in therapy (below 10 years). A survey on Singapore MHPs (N = 122) by Ang (2001) found that they had less than 10 years of experience in therapy. Comparatively, a survey of Korean MHPs by Bae, Joo, and Orlinsky, (2003) found that the majority of counsellors, nurse therapists, psychiatrists, and social workers had an average of 6 years in therapy experience. As mentioned, perhaps, mental health development in New Zealand parallels those of Europe and the United States, and Singapore's matches that of Korea. It may also imply the temporal effects of the spread of Western therapy to the East.

Two samples of MHPs of this study (New Zealand psychologists and Singapore psychiatrists) conform to the existing ruling to register for practice. If it were, however, mandatory for all MHPs to do so, just as would licensing for practice for MHPs in other countries (e.g., psychologists in the United States), clients would be better assured in the provision of professional mental health services. As highlighted, New Zealand, together with Australia, have already drawn up clinical practice guidelines for carers and consumers (Lammersma, 2005). The Singapore Psychological Society has recently endeavoured to have all its psychologists register for practice (Singapore Psychological Society, 2004).

Differences in Practice Characteristics

New Zealand MHPs rely more heavily on therapy approaches that have a strong empirical support (see Roberts & Yeager, 2004, for a good account of evidence-based research and practice). By contrast, Singapore MHPs continue to put considerable

weight on practitioner's personal preference, and this probably reflects the long-standing powerful influences of traditional spiritual and culture-specific beliefs and practices of everyday Singaporean life.

The difference in number of therapy sessions with clients between New Zealand and Singapore MHPs may be explained by clients' expectation of therapy services. Clients of New Zealand MHPs are generally Caucasians, and as Western therapy is an essential part of their way of life, it will be used as required. Whereas clients of Singapore MHPs who are generally Chinese, and given their preference for quick solution to mental health problems, it is foreseeable for Singapore MHPs to have fewer number of therapy sessions. Additionally, the availability of insurance coverage for therapy in New Zealand funds the use of its services. This type of insurance coverage, however, is presently not available in Singapore. Further credence comes from the definition of short-term CBT by MHPs. The application of CBT desires that MHPs predetermine the number of sessions, preferably between 10 and 15 (Wells, 1997). New Zealand sample would define 10 to 20 sessions for short-term CBT, whereas Singapore MHPs would define 6 sessions or less, for treatment of general mental disorders. Perhaps, this is due back to the expectations of clients.

Similarities and differences in characteristics, self-reported practices and experiential skills between New Zealand and Singapore MHPs obtained from this study serve three purposes. First, they provide limited profiles of Western-trained therapists in these countries. Secondly, they reflect the degree of influence of Western psychology and therapy in these countries, and give an idea of their cross-cultural application. Lastly, they give an idea to the kind of mental health services available in both these

countries. The major findings of this study are given below with implications (see Table 8.1).

Table 8.1
Main Findings of this Study with Implications

Similarities in Profiles of New Zealand and Singapore MHPs	**Implications**
1. There are more females than males MHPs.	1. Perhaps females are more incline to therapy.
2. Ratios of MHPs are representative of their population ethnic ratio.	2. Representative ratio is appropriate to provision of mental health services.
3. English is the common medium used in therapy.	3. Supporting English as an international language.
4. All MHPs are trained and qualified in Western therapy.	4. Formal qualification in therapy is necessary for practice.
5. Western therapy models and interventions are used mainly in assessment, diagnosis and treatment of mentally ill clients.	5. Western therapy has gained widespread use.
6. The CBT model is most used among therapy approaches.	6. CBT is gaining acceptance as the choice of treatment.
7. Western therapy is found to be relevant to all clients, but need to be modified for non-Caucasian clients.	7. Western therapy can be used with any client, just suit it to the client's culture.
8. Most MHPs subscribe to minimal self-disclosure in session, discussion of religious or spiritual issues, and use of traditional healing services of clients.	8. Always respect traditional healing systems and services of clients regardless.
Differences in Profiles of New Zealand and Singapore MHPs	**Implications**
New Zealand MHPs	
1. They are generally older (over 41 years of age) with more years of experience in therapy (over 11 years).	1. Could be a Western trend.
2. They rely more on therapy approaches that have emphasis on empirical support.	2. Western therapists are more scientifically-inclined.
3. Their psychologists are trained mainly in clinical psychology.	3. Clinical psychology has the appeal to therapy.
4. Generally, they have more therapy sessions with clients (an average of 10).	4. Western clients are open to therapy.

Table 8.2 (continued)

Singapore MHPs	
1. They are generally younger (below 40 years of age) with fewer years of experience in therapy (less than 10 years).	1. Could be an Eastern trend that Western therapy is gaining inroads.
2. They put more weight on personal or client's preference for therapy approaches.	2. Traditions and customs of people are important.
3. Their therapy training is mainly by way of supervision.	3. A lack of formal clinical training services.
4. Generally, they have fewer therapy sessions with clients (an average of 6).	4. Clients are particular about Western therapy services.

Implications for Chinese Clientele and Cognitive Behaviour Therapy

As discussed earlier, among the various orientations of psychological models and treatment interventions used in Western therapy (David & Szentagotai, 2006; Reinecke & Davidson, 2002; Woolfe, Dryden, & Strawbridge, 2003), the theoretical framework and practicality of CBT apparently suits the expectations of Chinese clientele (Bentelspacher, DeSilva, Goh, & LaRowe; Chen & Davenport, 2005; Foo & Kazantzis, in press; Hong & Domokos-Cheng Ham, 2001; Huat, 1996; Kazantzis, Deane, Ronan, & L'Abate, 2005; Kee, 2004; Lee, 2002; Merrick & Dattilio, 2006; Soong, 2001; Williams, Foo, & Haarhoff, 2006; Williams, Graham, & Foo, 2004). Results of this study not only support the efficacy of Western psychology and therapy with multicultural clients, but also the applicability of CBT on Chinese New Zealander and Singaporean clients.

Suffice to mention, based on the rich information on Chinese clients conveyed through literature (e.g., Chen & Davenport, 2005; Chu; 1999; Chua, 2003; Eyou, Adair, & Dixon, 2000; Ho, 1986; Ho, Au, Bedford, & Cooper, 2003; Hong & Domokos-Cheng Ham, 2001; Kee, 2004; Lee, 2002; Lee & Bishop, 2001; Leslie, 1979; Lim & Bishop, 2000; Ngai, Latimer & Cheung, 2000; Sim, 1999; Huat, 1994; Thomas, 1990; Wong, 2001), and augmented by the findings of the present study (Foo & Merrick, 2004; Foo, Merrick, Katzantzis, & Williams, 2006), the following considerations are proposed for conducting Western therapy with them (see Table 8.2).

Table 8.2
Considerations for conducting Therapy with Chinese Clients

Factors	Descriptions and Implications for Clients
Perception of:	
(1) Western medicine	(1) Is for treating diseases when symptoms are acute; standard doses.
(2) Herbal medicine	(2) Is used Western medicine is not helping, suitable for less psychologically distressing or spiritual difficulties, holistic, and individually tailored; comes with a diet change recommendation.
Beliefs in mental illness	Stigma, contagious; person in therapy same as mentally ill person. Causal attribution to external events, i.e., external locus of control (bad luck or fate).
Priority in help-seeking or coping behaviours for mental illness	(1) First, self-help (e.g., problem-solve, stay at home, keep occupied, ignore problem, endure psychologically, avoid situation, self-control, take tonic drinks/purging medicine/vitamins/ minerals or go on special diet). (2) Next, get help from relatives, peers, or friends. (3) Then, get help from social resources. (4) Then, appeal to religious beliefs, supernatural powers, and traditional healers. (5) Lastly, seek help from mental health practitioners.
Western therapy:	
(1) Referral	(1) Usually by word of mouth (reputable mental health professionals preferred).
(2) Supporting services	(2) Preferably be adjacent e.g., psychological testing centers, pharmacy and psychiatric clinic (for convenience).
(3) Appointment	(3) Preferably be immediate (desire quick fix).
(4) Setting	(4) Expect therapeutic environment that provides confidentiality and privacy (no sign of "madness"); supportive staff (not obsequiousness or business-mindedness); short waiting (use to fast-moving behaviours).
(5) Therapist	(5) Expect to be formally dressed; regularly present (presence of multicultural or cross-cultural therapists an asset; if not, have interpreter present); expect to be experts or teachers (respect authority; used to hierarchy).

Table 8.2 (continued)

Factors	Descriptions and Implications for Clients
(6) Treatment	(6) Expect outline of process; include issues of rights and confidentiality, expectations, number of sessions (preferred few; that is quick fix, value for money), treatment plan and fees (remove uncertainties about therapy).
(7) Diagnosis	(7) Expect to include cultural explanations for presenting problem or symptoms (show understanding by therapist).
(8) Initial sessions	(8) Expect rapport building first, including therapist self-disclosure, then look at needs and set goals; not to talk about relationships unless the client brings it up; (cultural practices of first "get to know you" then go straight to point in discussion).
	Therapist to do:
If CBT approach is used: include pre-therapy induction, culturally appropriate strategies, respect collective coping strategies, and provide immediate results.	Use psychoeducation frequently (desire for information).
	Modify approach accordingly (e.g., use languages of clients, Chinese metaphors, proverbs and folk stories, Confucianism, Buddhism, etc).
	Use less confrontational, less assertive and less emotionally intense, solution-focused, problem-focused, eclectic approach (prefer structured, quick fix, advice-giving sessions, solved problems for me, or do something for a change expectation).
	Use directive approach often (non-directive approach may be too much of a radical change for most)
	Use non-directive approach (preferred by those in the higher socio-economic status, English-educated and more Westernized).
If client-centered approach is used: combine with directive measures.	Give therapy homework (seen as additional help to problem-solving; probably due to attitude towards academic achievement and recognition).
	Include traditional healing practices (cultural practice). Harness family for support (collectivism).
	Use appropriate psychological assessment procedures (outcome-oriented).
(9) Termination	(9) Dependence or idealization of therapist (difficulty in termination of therapy).
Family Therapy	Necessary for success of therapy (but look out for family hierarchy, values, beliefs, parenting styles).
Group Therapy	Therapist to do:
	Provide structure, clear instructions and rationale for it; therapist may have to lead the way (culturally less inclined to self-disclose in front of others; keep "secrets" to themselves).

Most invaluable were two experiential disclosures made by Hong Kong psychologists, reaped from their 30 years of practice, at the Asian CBT Conference (Wong, 2006). The first disclosure was that CBT works for everyone, for that matter any therapy model works for anyone, the difference lies in tailoring activities according to the client's own cultural activities. The second disclosure was that Chinese clients tend to use perceptual thinking compared with Western clients who are used to conceptual thinking. For example, to make Chinese clients understand the concept of the CBT 5-part model (Beck's; Beck, 1995), it is preferable to start with the emotion or

feeling factor, and then go onto cognition and other factors. Starting with the cognition factor will lead to difficulty in comprehension. For Western clients, learning the CBT 5-part model may begin with any part of the model because they are accustomed to looking at the "big picture" of situations.

Two additional factors for MHPs to consider when working with Chinese clients are noted here. First, therapy models like schema therapy use the confrontational style to treat problems of clients (Young, 1999). Notably, Chinese clients (the same goes for Asian clients) will not be accepting of a confrontational approach taken by female therapists because the culturally appropriate role for women is to be emphatic and understanding, and that may lead to premature termination of treatment by the client. This behaviour is otherwise tolerated in male therapists (McEachern & Kenny, 1999). Second, Chinese clientele were remarkable for having a personal agenda when attending therapy sessions (Soong, 1997; Wong, 2001).

Taken together, CBT might be the choice of therapy for Chinese clients. It is up to the therapist to devise methods to suit the cultural demands of the client yet fulfil the necessities of the model.

Limitations of the Study

The response rate for the mail questionnaire was 20% for New Zealand participants and 27% for Singapore participants despite the follow-up reminder letter sent four weeks after posting. While it is difficult to be certain about the relatively low response rate, several explanations are possible. Retrospectively, it was discovered that the New Zealand sample had been saturated by a series of research questionnaires over the previous 18 months, thus, influencing the willingness of New Zealand participants

to complete yet another questionnaire. Again it is speculated that as far as the Singapore participants are concerned, the relatively low response rate may reflect a general lack of interest and culture surrounding research practices in therapy, and possibly some degree of suspiciousness among large Singapore organisations employing MHPs. In a New Zealand survey by Ngai, Latimer and Cheung (2000), the response rate, from health professionals in Auckland at 30%, was considered low. In a Singapore study by Parker, Lee, Chen, Kua, Loh and Jorm (2001), which obtained a response rate of 38%, the researchers concluded that Singapore general practitioners might be generally reluctant to respond to surveys.

A further limitation was evident when the responses of both New Zealand and Singapore samples of MHPs were considered. Most of New Zealand MHPs were formally trained clinical psychologists. By contrast, Singapore MHPs were drawn from a much diverse and less clearly defined clinical background, rather a mix of counsellors, psychiatrists, psychologists, psychotherapists and social workers. Only the psychiatrists in the Singapore sample had a uniform training base.

The mail questionnaire did generate the most of the desired results as evidenced in the support of the hypotheses, but did carry some terms that caused differing interpretations from the diverse groups of MHPs in both countries. For example, some MHPs did not like the term "client" but preferred "patient"; some found terms like "basis", "relevance", "traditional healers" and "in-patient/outpatient" too broad to be addressed adequately. It corroborates the fact that subtleties in the usage and interpretation of the English language exist between native-English speakers (New Zealanders) and adopted-English speakers (Singaporeans). Additionally, it highlights the choice of words among MHPs, who are trained in their own professional language

and terminology. If the questionnaire were used within one country, differing interpretations to questions and terms may not occur.

Recommendations for Future Research

Conducting a study with diverse participants such as MHPs requires an immaculately designed questionnaire to suit every participant's choice of questions or terms, as well as a very large sample to be able to obtain significant results. Perhaps, it would be wiser to focus on just one particular professional group for better research outcomes—for example, psychologists, who are of a more homogenous group.

Another way of possibly conducting this study is via the grounded theory. Grounded theory is the systemic and intensive analysing and comparing in fine details to produce a well-constructed theory (Yates, 2004). It has been characterised as an empiricist programme of social investigation. The first criterion is that it should fit the data and not be forced onto it. The second criterion is that it should be meaningfully relevant to the topic under study (Williams, May, & Wiggins, 1996).

Given the present load of research demands on MHPs by the various universities, they could have been saturated or habituated to another study about themselves and their practices. Perhaps, merely giving general topics to MHPs and asking them to jot down whatever that comes to mind related to therapy may produce startling results yet contemplated. This is not an unfounded recommendation as feedback from the participating MHPs suggested dropping standard questions on therapy, and instead requesting information on pertinent concerns like policy and funding for therapy, content of transference and counter-transference, content of cross-cultural therapy training and supervision, and professional development. Some of these

concerns have been addressed in studies (e.g., Blanchard & Lichtenberg, 1998; Case, 1997; the series of studies by the Collaborative Research Network of the Society for Psychotherapy Research, Orlinsky, Ambühl, Rønnestad, Davis, Gerin, & Davis et al., 1999). Perhaps, this study could be better conducted with just interviews with MHPs and clients. Data drawn from the latter would provide the necessary corroboration.

Given the nuances in usage of the English language by New Zealanders and Singaporeans, coupled with feedback from participating MHPs on the choice of terms used in the questionnaire, it would interesting to investigate the effects of English usage in therapy between multicultural therapists and clients.

Managing multicultural clients entail much more than therapy skills alone. The few experiential skills examined here is just a tip of the iceberg in the study of such therapy skills of MHPs. Perhaps, future research could look into related therapy skills as in conducting family and group therapy with multicultural clientele.

Conclusion

This study represents an initial attempt to highlight the portraits of New Zealand and Singapore MHPs depicting their characteristics, practices, and experiential skills. Ideally, a fully representative sample of MHPs from both countries might be obtained. There are significant practical difficulties, however, in obtaining up-to-date inclusive listings of MHP groupings in New Zealand and Singapore. To the extent that it was possible, considerable effort was made to obtain responses from a representative sample of MHPs working in mental health settings from both countries.

The results of this study did suggest that there are more similarities than differences in the portraits and experiential skills of MHPs in New Zealand and

Singapore. However, findings relating to the influence of traditional spiritual and cultural beliefs on counselling and psychotherapy practices in both countries suggest that they are not well integrated. A clearer understanding and knowledge of traditional models of health and healing could well enrich current Western practices and increase the efficacy and acceptance of mental health practices in both countries. In the least, the findings of this study provide a guide to managing Chinese and their mental illness.

This study has highlighted the importance of cross-cultural therapy, particularly the concerns, beliefs and practices of clients. Perhaps, multicultural psychology training programmes need to consider culture-specific techniques in their teachings of psychology and therapy. Furthermore, ideally, issues surrounding adequate, comprehensive therapy training with formal registration and monitoring of these by government agencies would ensure higher standards and competency in practice not only nationally but also across cultural divides.

A number of studies have indicated an increasing demand for multicultural counselling and psychotherapy services in New Zealand and Singapore (Abbott, Wong, Williams, Au & Young, 2000; Chong & Ow, 2003; Ngai, Latimer & Cheung, 2000; Ng, Fones & Kua, 2003; Walker, Wu, Soothi-O-Soth & Parr, 1998; Yeo, 2004). A lack of multicultural competence in therapy can be remedied through learning from literature (e.g., the book by Sue & Sue, 2003, provides a good account on this), or participation in multicultural workshops and clinical work with diverse clients (Dipasquale, 2004). However, cross-cultural therapy with Chinese clients or clients from any ethnic group is not very different. As Culbertson (2001) put it, counselling or psychotherapy is not foreign to the Chinese, only the process is different; likewise, for other ethnic groups. In a nutshell, to treat the mental illness of Chinese clientele, bear in mind their attitudes and beliefs towards mental illness, accept their help-seeking behaviours, use the eclectic

approach or integrate approaches, and modify the approach accordingly. It is hoped that this study goes some way towards addressing these complex but fascinating issues.

REFERENCES

Abbott, M. W., Wong, S., Williams, M., Au, M. K., & Young, W. (2000). Recent Chinese migrants' health, adjustment to life in New Zealand and primary health care utilization. *Disability and Rehabilitation, 22*(1/2), 43-56.

Al-Krenawi, A. (1999). An overview of rituals in Western therapies and intervention: Argument for their use in cross-cultural therapy. *International Journal for the Advancement of Counselling, 21*, 3–17.

Allwood, C. M. (2002). Indigenized psychologies. *Social Epistemology, 16*, 349–366.

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed., Rev.). Washington, DC: Author.

Ancis, J. R., & Szymanski, D. M. (2001). Awareness of White privilege among White counseling trainees. *Counselling Psychologists, 29*(4), 548-569.

Anderson, E. N., & Anderson, M. L. (1978). Folk dietetics in two Chinese communities, and its implications for the study of Chinese medicine. In A. Kleinman, P. Kunstadter, E. R. Alexander, & J. L. Gate (Eds.), *Culture and healing in Asian societies: Anthropological, psychiatric and public health studies* (pp. 69-100). Boston: G. K. Hall.

Ang, A. (1999). Why doctors should learn counselling and psychotherapeutic skills. *Singapore Medical Journal, 40*(03), 128-9.

Ang, A. W. K. (2001). The views of mental health professionals towards psychotherapy—a Singapore survey. *Annals Academy of Medicine Singapore, 30*, 38-43.

Ang, R. P., Lim, K. M., & Tan A-.G. (2004). Effects of gender and sex role orientation on help-seeking attitudes. *Current Psychology: Developmental, Learning, Personality, Social, 23*(3), 203-214.

Bae, S. H., Joo, E., & Orlinsky, D. E. (2003). Psychotherapists in South Korea: Professional and practice characteristics. *Psychotherapy: Theory, Research, Practice, Training, 40*(4), 302–316.

Ball, J., Mustafa, S. M., Moselle, K. A. (1994). Cultural influences on help-seeking for emotional problems: A study of Malay young adults. In G. Davidson (Ed.), *Applying psychology: Lessons from Asia-Oceania* (pp. 97-112). Brisbane, Australia: Australian University Press.

Ballen, J. R. (1999). Boundaries: Metaphors of meaning in psychotherapeutic relationships. [Dissertation Abstract] *Dissertation Abstracts International: Section B: The Sciences and Engineering, 60*(2-B), 0818.

Banerjee, S. P. (1999, April). Behavioral psychotherapy in Singapore. *Behavior Therapist, 22*(4), 80, 91.

Banks, N. (1999). *White counsellors--Black clients: Theory, research and practice.* Aldershot, England: Ashgate.

Barrett, P. (2001, March). *Assessing the reliability of rating data.* Retrieved April 18, 2006, from http://www.pbarrett.net/statistics_corner.htm#intrerrater

Beck, J. S. (1995). *Cognitive therapy: Basic and beyond.* London: The Guilford Press.

Bentelspacher, C. E., DeSilva, E., Goh, T. L. C., & LaRowe, K. D. (1996). A process evaluation of the cultural comparability of psychoeducational family group treatment with ethnic Asian clients. *Social Work with Groups, 19*(3/4), 41-55.

Berman, M. C. (1999). Integrating spirituality into psychological practice. (Buddhism). [Dissertation Abstract] *Dissertation Abstracts International: Section B: The Sciences and Engineering, 59*(11-B), May 1999, 6059.

Bilgrave, D. P., & Deluty, R. H. (1998). Religious beliefs and therapeutic orientations of clinical and counseling psychologists. *Journal for the Scientific Study of Religion, 37*(2), 329-349.

Blampied, N. M. (1999). Cognitive-behaviour Therapy in Aotearoa, New Zealand. *The Behavior Therapist*, 173-178.

Blampied, N. M. (2001). The third way: Single-case research, training and practice in clinical psychology. *Australian Psychologist, 36*(2), 157-163.

Blanchard, C. A., & Lichtenberg. (1998). Counseling psychologists' training to deal with their sexual feelings in therapy. *The Counseling Psychologist, 26(*4), 624-639.

Boller, J. L., & Lee, S. S. (1997). *Nonsexual touch, self-disclosure, and friendship in the therapeutic setting: A discussion of boundary issues.* South Orange, NJ: Seton Hall University.

Bryan, L. A., Dersch, C., Shumway, S., & Arredondo, R. (2004). Therapy outcomes: Client perception and similarity with therapist view. *American Journal of Family Therapy, 32*(1), 11-26.

Bryson, J., & Hosken, C. (2005). What does t mean to be a culturally competent I/O psychologist in New Zealand? *New Zealand Journal of Psychology, 34*(2), 69-76.

Burkard, A. W., Knox, S., Groen, M., Perez, M., & Hess, S. A. (2006). European American therapist self-disclosure in cross-cultural counseling. *Journal of Counseling Psychology, 53*(1), 15–25.

Case, P. W. (1997). Potential sources of countertransference among religious therapists. *Counselling and Values, 41,* 97-106.

Chambliss, C. (2000*). Challenges confronting counseling education program: Is therapy truly representative?* Collegeville, PA: Ursinus College.

Chen, C.-N., Wong, J., Lee, N., Chan-Ho, M.-W., Lau, J. T.-F., & Fung, M. (1993). The Shatin community mental health survey in Hong Kong. *Archives of General Psychiatry, 50,* 125-133.

Chen, S. W.-H., & Davenport, D. S. (2005). Cognitive-behavioural therapy with Chinese American clients: Cautions and modifications. *Psychotherapy: Theory, Research, Practice, Training, 42*(1), 101-110.

Cheng, A. T. A., Tien, A. Y., Chang, C. J., Brugha, T. S., Cooper, J. E., Lee, C. S., et al. (2000). Cross-cultural implementation of a Chinese version of the schedules for clinical assessment in neuropsychiatry (SCAN) in Taiwan. *British Journal of Psychiatry, 178*, 567-572.

Cherrington, L. (1994). *A comparison study of the presenting symptoms between Māori and Pakeha patients diagnosed with schizophrenia*. Unpublished master's thesis. Massey University, Palmerston North, New Zealand.

Cheung, F. M. C. (1986). Psychopathology among Chinese people. In M. H. Bond (Ed.), *The psychology of Chinese people* (pp. 170-212). Hong Kong: Oxford University Press.

Chong, S. A., Lee, C., & Verma, S. (2004). A risk reduction approach for schizophrenia: The early psychosis intervention programme. *Annals Academy of Medicine Singapore, 33*(5), 630-635.

Chong, L.-H., & Ow, R. (2003). Licensure and the ethical practice of counseling in Singapore. *Asian Journal of Counselling, 10*(1), 33-49.

Chu, S.-H. (1999). Multicultural counselling: An Asian American perspective. In D. S. Sandhu (Ed.), *Asian and Pacific Islander Americans: Issues and concerns for counselling and psychotherapy* (pp. 21-30). New York: Nova Science.

Chua, E. L. M. (2003). A return to spirituality: When eastern philosophy meets western practice. *Journal of Family Psychotherapy, 14*(1), 23-35.

Cobiac, L. (1998). Traditional Chinese medicine seminar: Singapore, 7 March 1998. *Australian Journal of Nutrition & Dietetics, 55*(2), 92-93.

Coney, S. (1995). New Zealand investigates mental health services. *The Lancet, 346*(8990), 1620.

Cornett, C. (1998). *The soul of psychotherapy: Recapturing the spiritual dimension in the therapeutic encounter*. New York: Free Press.

Culbertson, P. (Ed.). (2001). *The GM resource and referral directory 2001* (10th ed.). Auckland, New Zealand: GM Media.

Cunningham, J. (1999). Counter the counselling culture. *Living Marxism, 118*, 12-14.

David, D., & Szentagotai, A. (2006). Cognitions in cognitive-behavioral psychotherapies; toward an integrative model. *Clinical Psychology Review, 26*, 284– 298.

Department of Internal Affairs. (2006). *Let's talk: Guidelines for government agencies hiring interpreters.* Wellington, New Zealand: Author.

Deva, M. P. (2004). Malaysia mental health country profile. *International Review of Psychiatry, 16*(1–2), 167–176.

Devan, G. S. (2001). Culture and the practice of group psychotherapy in Singapore. *International Journal of Group Psychotherapy, 51*(4), 571-577.

Devins, G. M., Beiser, M., Dion, R., Pelletier, L. G., & Edwards, R. G. (1997). Cross-cultural measurements of phychological [*sic*] well-being: The psychometric equivalence of Cantonese, Vietnamese, and Laotian translations of the affect balance scale. *American Journal of Public Health, 87*(5), 794-799.

Dienhart, A. (2001). Engaging men in family therapy: Does gender of the therapist make a difference? *Journal of Family Therapy, 23*, 21-45.

Dipasquale, A. (2004). Relationships of therapist characteristics with self-reported multicultural competence. [Dissertation Abstract] *Dissertation Abstracts International: Section B: The Sciences and Engineering, 65*(3-B), 1543.

Dwairy, M. (1999). Toward psycho-cultural approach in middle-eastern societies. *Clinical Psychology Review, 19*(8), 909-915.

Edman, J. L., & Koon, T. Y. (2000). Mental illness beliefs in Malaysia: Ethnic and intergenerational comparisons. *International Journal of Social Psychiatry, 46*(2), 101-109.

El-Islam, F., & Abdel-Razek. (1993). Effects of mood abnormality on responses to a personality questionnaire. *The Arab Journal of Psychiatry, 4(2)*, 77-83.

Elliot, J. M. (1999). Studies in psychology. In B. H. Chua (Ed.), *Singapore studies II: Critical surveys of the humanities and social sciences* (pp. 182-203). Singapore: Singapore University Press.

Emmons, R. A., & Paloutzian, R. F. (2003). The psychology of religion. *Annual Review of Psychology, 54*, 377–402.

Esters, I. G., & Ittenbach, R. F. (1997). Today's IQ tests: Are they really better than their historical predecessors? *School Psychological Review, 26(2)*, 211-223.

Evans, I. M. (2002). Clinical psychology in early 21st Century Aotearoa/New Zealand: Introduction to the special issue. *New Zealand Journal of Psychology, 31*(2), 50-2.

Eyou, M. L., Adair, V., & Dixon, R. (2000). Cultural identity and psychological adjustment of adolescent Chinese immigrants in New Zealand. *Journal of Adolescence 2000, 23*, 531–543.

Foo, K. H., & Kazantzis, N. (in press). Integrating homework assignments based on culture: Working with Chinese patients. *Cognitive and Behavioral Practice,*.

Foo, K. H., & Merrick, P. L. (2004). Practitioner characteristics with comparison of counselling and psychotherapy practices between New Zealand and Singapore mental health practitioners. In S. Tse, A. Thapliyal, S. Garg, G. Lim, & M. Chatterji, *Proceedings of the inaugural international Asian health conference: Asian health and wellbeing, now and into the future* (pp. 223-239). New Zealand: The University of Auckland, School of Population Health.

Foo, K. H., Merrick, P. L., & Kazantzis, N. (2006). Counselling/Psychotherapy with Chinese Singaporean clients. *Asian Journal of Counselling, 13*(2), 271-293.

Foo, K. H., Merrick, P. L., Kazantzis, N., & Williams, M. W. (2006, May). Cognitive behaviour therapy in New Zealand and Singapore: From a doctoral study and personal experience. In L. Hatzipetrou (Chair), *CBT programs in Asian-Pacific Regions*. Symposium conducted at the 1st Asian Cognitive Behaviour Therapy (CBT) Conference: Evidence-based Assessment, Theory & Treatment, The Chinese University of Hong Kong, Hong Kong.

Gold, J. (2002). Integrative approaches to psychotherapy. *Encyclopedia of Psychotherapy*, 25-35.

Greene, J. C and Caracelli V.J. (Ed.). (1997). *Advances in mixed-method evaluation: The challenges and benefits of integrating diverse paradigms.* San Francisco: Jossey-Bass Publishers.

Greenberg, D., & Witztum, E. (1991). Problems in the treatment of religious patients. *American Journal of Psychotherapy, 45*(4), 554-565.

Gupta, A. F. (1994). *The step-tongue: Children's English in Singapore.* Clevedon, Avon, England: Multilingual Matters Ltd.

Hall, M. E. L., & Hall, T. W. (1997). Integration in the therapy room: An overview of the literature. *Journal of Psychology and Theology, 25*(1), 86-101.

Halliday-Boykins, C. A., Schoenwald, S. K., & Letourneau, E. J. (2005). Caregiver-therapist ethnic similarity predicts youth outcomes from an empirically based treatment. *Journal of Consulting and Clinical Psychology, 73*(5), 808-818.

Ho, D. Y. F. (1986). Chinese pattern of socialization: A critical review. In M. H. Bond (Ed.), *The psychology of Chinese people* (pp. 1-37). Hong Kong: Oxford University Press.

Ho, E., Au, S., Bedford, C., & Cooper, J. (2003). *Mental health issues for Asians in New Zealand: A literature review*. New Zealand, Mental Health Commission.

Ho, L. S. M. (2000). *The relationship between personality and counselling orientation.* Unpublished masters' thesis. National Institute of Education, Nanyang Technological University, Singapore.

Hollanders, H., & McLeod, J. (1999). Theoretical orientation and reported practice: A survey of eclectism among counsellors in Britain. *British Journal of Guidance & Counselling, 27*(3), 405-414.

Hong, G. K., & Domokos-Cheng Ham, M. (2001). *Psychotherapy and counseling with Asian American clients: A practical guide.* Thousand Oaks, CA: Sage.

Hong, Y. Y., Morris, M. W., Chiu, C. Y., & Benet-Martinez, V. (2000). Multicultural minds: A dynamic constructivist approach to culture and cognition. *American Psychologist*, *55*(7), 709-720.

Huat, T. B. (1994). Therapeutic paradox: Its use and function in therapy in a predominantly Chinese society. In G. Davidson (Ed.), *Applying psychology: Lessons from Asia-Oceania* (pp. 61-81). Brisbane, Australia: Australian University Press.

Inoguchi, T., & Newman, E. (1997). "Asian Values" and democracy in Asia. In *Proceedings of a conference as part of the first Shizuoka Asia-Pacific forum: The future of the Asia-Pacific region.* Shizuoka, Japan: Hamamatsu.

Inskipp, F. (2000). Generic skills. In C. Feltham & I. Horton (Eds.), *Handbook of counselling and psychotherapy* (pp. 74-93). London: Sage.

Jacobs, M. (2000). Psychotherapy in the United Kingdom: Past, present and future. *British Journal of Guidance & Counselling, 28*(4), 451-466.

Jespersen, S., & Herring, R. D. (1993). *International counseling: An opportunity for cultural-specific counseling with the New Zealand Māori.* Little Rock, AR: University of Arkansas.

Johnstone, K. (1997). Māori mental health: A survey of psychologists' and psychiatrists' opinions. Unpublished masters thesis. University of Auckland, Auckland, New Zealand.

Johnstone, K., & Read, J. (2000). Psychiatrists' recommendations for improving bicultural training and Māori mental health services: A New Zealand survey. *Australian and New Zealand Journal of Psychiatry, 34*, 135-145.

Joseph, N. (1993). Religious psychotherapists. *Free Inquiry, 13*(3), 24-25.

Karlsson, R. (2005). Ethnic matching between therapist and patient in psychotherapy: An overview of findings, together with methodological and conceptual issues. *Cultural Diversity and Ethnic Minority Psychology, 11*(2), 113–129.

Katz, B., Juni, S., & Matz, P. (2003). The values of psychoanalytic psychotherapists at two points in time (1979 vs. 1993): A cross-over comparative study. *Current Psychology: Developmental, Learning, Personality, Social, 21*(4), 339-361.

Kazantzis, N., & Deane, F. P. (1998). Theoretical orientations of New Zealand psychologists: An international comparison. *Journal of Psychotherapy Integration, 8*(2), 97-113.

Kazantzis, N., Deane, F. P., Ronan, K. R., & L'Abate, L. (Eds.). (2005). *Using homework assignments in cognitive behavior therapy*. London: Routledge, Taylor & Francis Group.

Kee, C. H.-Y. (2004). Cultural features as advantageous to therapy: A Singaporean perspective. *Journal of Systemic Therapies, 23*(4), 67-79.

Kelly, E. W., Jr. (1995). Counselor values: A national survey. *Journal of Counseling & Development, 73*, 648-653.

Kim, B. S. K., Ng, G. F., & Ahn, A. J. (2005). Effects of client expectation for counseling success, client-counselor worldview match, and client adherence to Asian and European American cultural values on counseling process with Asian Americans. *Journal of Counseling Psychology, 52*(1), 67–76.

Kim, B. S. K., & Omizo, M. M. (2005). Asian and European American cultural values, collective self-esteem, acculturative stress, cognitive flexibility, and general self-efficacy among Asian American college students. *Journal of Counseling Psychology, 52(*3), 412–419.

Kim, U. (2000). Indigenous, cultural, and cross-cultural psychology: A theoretical, conceptual, and epistemological analysis. *Asian Journal of Social Psychology, 3*, 265-287.

Kong, S. (2005). Day treatment programme for patients with eating disorders: Randomized controlled trial. *Journal of Advanced Nursing, 51*(1), 5–14.

Krieble, T. (2003). Towards an outcome-based mental health policy for New Zealand *Australasian Psychiatry, 11*(Supp), 78-82.

Kua, E. H. (2004). Focus on psychiatry in Singapore. *British Journal of Psychiatry, 185*, 79-82.

Kuo, P. Y., & Roysircar-Sodowsky, G. (1999). Political ethnic identity versus cultural ethinic identity: An understanding of research on Asian Americans. In D. S. Sandhu (Ed.), *Asian and Pacific Islander Americans: Issues and concerns for counselling and psychotherapy* (pp. 71-90). New York: Nova Science.

Lambert, M. J. (2004). *Bergin and Garfield's handbook of psychotherapy and behaviour change* (5th ed.). New York: John Wiley & Sons.

Lammersma, Jo. (2005). From the CEO. *Australasian Psychiatry 13*(2), 205.

Le Fevre, P. D., & Goldbeck, R. (2001). Cognitive-behaviour therapy: A survey of the training, practice and views of Scottish psychiatrists. *Psychiatric Bulletin, 25*, 425-428.

Lee, B. O. (2002). Chinese indigenous psychotherapies in Singapore. *Counselling and Psychotherapy Research, 2*(1), 2-10.

Lee, B. O. & Bishop, G. D. (2001). Chinese clients' belief systems about psychological problems in Singapore. *Counselling Psychology Quarterly, 14*(3), 291-240.

Lee, N. B. C., Fung, D. S. S., Teo, J., Chan, Y. H., & Cai, Y. M. (2003). Five-year review of adolescent mental health usage in Singapore. *Annals Academy of Medicine Singapore, 32*(1), 7-11.

Leslie, R. C. (1979). Counseling across cultures. UMHE *Monograph Series*, number 5. Valley Forge, PA: UMHE Communication office. (ERIC Document Reproduction Service No. ED 186828)

Li, M., Duan, C., Ding, B., Yue, D. & Beitman, B. (1994). Psychotherapy integration in modern China. *Journal of Psychotherapy and Research, 3*, 277–283.

Lim, A. S. H., & Bishop, G. D. (2000). The role of attitudes and beliefs in differential health care utilisation among Chinese in Singapore. *Psychology and Health, 14*, 965-977.

Lippincott, J. A. (1999). Acculturative stress among Asians: Assessment and treatment issues. In D. S. Sandhu (Ed.), *Asian and Pacific Islander Americans: Issues and concerns for counselling and psychotherapy* (pp. 43-55). New York: Nova Science.

Liu, J. H., Wilson, M. S., McClure, J. & Higgins, T. R. (1999). Social identity and the perception of history: Cultural representations of Aotearoa/New Zealand. *European Journal of Social Psychology, 29*, 1021-1047.

Liu, J. H., Ng, S. H., Weatherall, A., & Loong, C. (2000). Filial piety, acculturation, and intergenerational communication among New Zealand Chinese. *Basic and Applied Social Psychology, 22*(3), 213–223.

Locke, D. C. (1992). *Increasing multicultural understanding: A comprehensive model.* Thousand Oaks, CA: Sage.

Long, F.Y. (1984). Psychology in Singapore: Its roots, contexts and growth. *The Singapore Professionals*, 9(1), 9-20.

Longhi, G. R. (2000). Cross-cultural substance abuse treatment: Clinical pathways to healing Native Americans and ourselves. [Dissertation Abstract] *Dissertation Abstracts International: Section B: The Sciences and Engineering, 60*(8-B), 4233.

Lo´pez, S. R., & Guarnaccia, P. J. J. (2000). Cultural psychopathology: Uncovering the social world of mental illness. *Annual Review of Psycholology, 51*, 571–598.

Loranger, A.W., Sartorius, N., Andreoli, A., Berger, P., Bucheim, P., Channabasavanna, S. M., et al. (1994). The International personality disorder examination: The World Health Organization/alcohol, drug abuse, and mental health administration international pilot study of personality disorders. *Archives of General Psychiatry, 51*(3), 215-224.

Love, C. M. A. (1999). *Māori voices in the construction of indigenous models of counselling theory and practice* (Vol 1). Unpublished doctoral thesis. Massey University, Palmerston North, New Zealand.

Lurie, S. (2005). Comparative mental health policy: Are there lessons to be learned? *International Review of Psychiatry, 17*(2), 97–101.

Mahrer, A. R., Fellers, G. L., Durak, G. M., Gervaize, P. A., & Brown, S. D. (1981). When does the counsellor self-disclose and what are the in-counselling consequences? *Canadian Counsellor, 15*(4), 175-179.

Maidment, J. (2000). Methods used to teach social work student in the field: A research report from New Zealand. *Social Work Education, 19*(2), 145-154.

Marie, D., Forsyth, D. K., & Miles, L. K. (2004). Categorical ethnicity and mental health literacy in New Zealand. *Ethnicity & Health, 9*(3), 225-252.

Maxie, A. C. (2002). Do therapists address differences in cross-cultural psychotherapy? [Dissertation Abstract] *Dissertation Abstract International: Section B: The Sciences & Engineering, 63*(6-B), 3015.

Maxie, A., Arnold, D. H., & Stephenson, M. (2006). Do therapists address ethnic and racial differences in cross-cultural psychotherapy? *Psychotherapy: Theory, Research, Practice, Training, 43*(1), 85–98.

McCabe, K. M. (2002). Factors that predict premature termination among Mexican-American children in outpatient psychotherapy. *Journal of Child and Family Studies, 11*(3), 347-359.

McClure, R. F., Livingston, R. B., Livingston, K. H., & Gage, R. (2005). A survey of practicing psychotherapists. *Journal of Professional Counseling: Practice, Theory, & Research 33*(1), 35-46.

McEachern, A. G., & Kenny, M. C. (1999). Sexual abuse in Asian and Pacific Islander populations: Current research and counseling implications. In D. S. Sandhu (Ed.), *Asian and Pacific Islander Americans: Issues and concerns for counselling and psychotherapy* (pp. 301-318). New York: Nova Science.

McLeod, M. K. (1999). *E iti noa ana na te aroha: A qualitative exploration into the realms of Māori healing.* Unpublished master's thesis. University of Waikato, Waikato, New Zealand.

Medical Council of New Zealand. (2004). *Homepage.* Retrieved June, 25, 2004, from http://www.mcnz.org.nz

Mental Health Commission. (1998). *Blueprint for mental health services in New Zealand: How things need to be.* Wellington, New Zealand: Author.

Merrick, P. L., & Dattilio, F. M. (2006). The contemporary appeal of cognitive-behaviour therapy. *New Zealand Journal of Psychology*, 35, 9-13g.

Miller, G. (2003). *Incorporating spirituality in counseling and psychotherapy: Theory and technique.* New Jersey: John Wiley & Sons.

Ministry of Health (2003). *Complementary and alternative medicine: Current policies and policy issues in New Zealand and selected countries.* Wellington, New Zealand: Ministry of Health.

Ministry of Health. (2004). *Improving mental health: The second national health and addiction plan 2005-2015: Consultation document.* Wellington, New Zealand: Ministry of Health.

Misumi, D. M. (1993). Asian American Christian attitudes towards counseling. *Journal of Psychology and Christianity, 12*(3), 214-224.

Naidoo, J. C., Olowu, A., Gilbert, A., & Akotia, C. (1999). Challenging EuroAmerican-centered psychology: The voices of African psychologists. In W. J. Lonner, D. L. Dinnel, D. K. Forgays, & S. A. Hayes (Eds.*), Merging past, present, and future in cross-cultural psychology: Selected papers from the fourteenth international congress of the international association for cross-cultural psychology* (pp. 124-134). The Netherlands: Swets & Zeitlinger.

Nathan, L., Wilson, N. J., & Hillman, D. (2003). *Te Whakakotahitanga: An evaluation of the Te Piriti Special Treatment Programme for child sex offenders in New Zealand.* Wellington, NZ: Department of Corrections.

Nelson-Jones, R. (2006). *Theory and practice of counselling and therapy* (4th ed.). London: Sage.

Neuendorf, K. A. (2002). *The content analysis: Guidebook.* London: Sage.

Newman, W. L. (2003). *Social research methods: Qualitative and quantitative approaches* (5th ed.). USA: Pearson Education, Inc.

Newell, R., & Gournay, K. (1994). British nurses in behavioural psychotherapy: A 20-year follow-up. *Journal of Advanced Nursing, 20*, 53-60.

New Zealand Association of Counsellors. (2004). *About NZAC*. Retrieved June 21, 2004, from http://www.nzac.org.nz

New Zealand Health Information Service. (2004, May 4). *Data & services*. Retrieved June 21, 2004, from http://www.nzhis.govt.nz

New Zealand Health Information Service (2005). *Mental health service use in New Zealand 2002*. Wellington, New Zealand: Ministry of Health.

New Zealand Psychologists Board. (2004, January 23). *Registered psychologists*. Retrieved June 21, 2004, from http://www.clinicalpsychologists.org.nz

Ng, P., & Chan, K.-F. (2000). Sex differences in opinion towards mental illness of secondary school students in Hong Kong. *International Journal of Social Psychiatry, 46*(2), 79-88.

Ng, S. C. (1999). *Christian social workers and counsellors: An exploratory study of their theoretical base for counselling*. Unpublished bachelor's thesis. National University of Singapore, Singapore.

Ng, T. P., Fones, C. S. L., & Kua, E. L. (2003). Preference, need and utilization of mental health services, Singapore National Mental Health Survey. *Australian and New Zealand Journal of Psychiatry, 37*(5), 613-619.

Ngai, M. M. Y., Latimer, S., & Cheung, V. Y. M. (2000). *Final report on healthcare needs of Asian people: Survey of Asian people and health professionals in the North and West Auckland*. Auckland, New Zealand: Asian Health Support Service, Waitemata District Health Board.

Noh, S., Kaspar, V., & Chen, X. (1998). Measuring depression in Korean immigrants: Assessing validity of the translated Korean version of CES-D scale. *Cross-cultural Research, 32(4)*, 358-377.

Norcross, J. C., Hedges, M., & Castle, P. H. (2002). Psychologists conducting psychotherapy in 2001: A study of the Division 29 membership. *Psychotherapy: Theory, Research, Practice, Training, 39*(1), 97–102.

Norusis, M. J. (2002). *SPSS 11.0 guide to data analysis*. NJ: Prentice Hall.

Olson, K. R. (2001). Computerized psychological test usage in APA-accredited training programs. *Journal of Clinical Psychology, 57(6)*, 727-736.

Oga, T. (2004). Rediscovering Asianness: The role of institutional discourses in APEC, 1989–1997. *International Relations of the Asia-Pacific*, 4(2), 287-317.

Orlinsky, D. E., Ambühl, H., Rønnestad, M. H., Davis, J. D., Gerin, P., & Davis, M. et al. (1999). Development of psychotherapists: Concepts, questions, and methods of a collaborative international study. *Psychotherapy Research, 9*(2), 127–153.

Orlinsky, D. E., & M. Ronnestad, H. (2005). *How psychotherapists develop: A study of therapeutic work and professional growth.* Washington, DC: American Psychological Association.

Ow, R. (1998). Mental health care: The Singapore context. *Asia Pacific Journal of Social Work, 8*(1), 120-130.

Padilla, A. M. (1999). Hispanic psychology: A 25-year retrospective look. In W. J. Lonner, D. L. Dinnel, D. K. Forgays, & S. A. Hayes (Eds.), *Merging past, present, and future in cross-cultural psychology: Selected papers from the fourteenth international congress of the international association for cross-cultural psychology* (pp. 73-81). The Netherlands: Swets & Zeitlinger.

Paewai, M. K. (1997). *Cultural safety within clinical psychology: A Māori perspective.* Unpublished master's thesis. University of Waikato, Waikato, New Zealand.

Parker, G., Chen, H., Kua, J., Loh, J., & Jorm, A. F. (2000). A comparative mental health literacy survey of psychiatrists and other mental health professionals in Singapore. *Australian and New Zealand Journal of Psychiatry, 34*, 627-636.

Parker, G., Mahendran, R., Yeo, S. G., Loh, M. I., & Jorm, A. F. (1999). Diagnosis and treatment of mental disorders: A survey of Singapore mental health professionals. *Social Psychiatry and Psychiatric Epidemiology, 34*, 555-563.

Parker, G., Lee, C., Chen, H., Kua, J., Loh, J., & Jorm, A. F. (2001). Mental health literacy study of general practitioners: A comparative study in Singapore and Australia. *Australasian Psychiatry, 9*(1), 55-59.

Patchett-Anderson, L. S. (1997). *Clinical psychologists' opinions about and uses of tests, assessments, and clinical intervention applications.* Unpublished master's thesis. Massey University, Palmerston North, New Zealand.

Poortinga, Y. H. (1995). Cultural diversity in Europe: Extrapolations from cross-cultural research for professional psychology. In J. Georgas, M. Manthouli, E. Besevegis, & A. Kokkevi (Eds.), *Contemporary Psychology in Europe: Theory, Research, and Applications. Proceedings of the IVth European Congress of Psychology* (pp. 345-359). Seattle, WA: Hogrefe & Huber.

Poortinga, Y. H. (1999). Do differences in behaviour imply a need for different psychologies? *Applied Psychology: An International Review, 48*(4), 419-432.

Raj, M. A. J., Kumaraiah, V., & Bhide, A. V. (2001). Cognitive-behavioural intervention in deliberate self-harm. *Acta Psychiatrica Scandinavica,104*(5), 340-345(6).

Raney, S., & Çinarbas, D. C. (2005). Counseling in developing countries: Turkey and India as examples. *Journal of Mental Health Counseling, 27*(2), 149–160.

Raza, F. (1997). *Ethnic identity, acculturation, and intergenerational conflict among second-generation New Zealand Indians.* Unpublished maters thesis. University of Auckland, Auckland, New Zealand.

Razali, S. M., & Najib, M. A. M. (2000). Help-seeking pathways among Malay psychiatric patients. *International Journal of Social Psychiatry, 46*(4), 281-289.

Read, J., & Harre, N. (2000). The role of biological and genetic causal beliefs in the stigmatisation of 'mental patients'. *Journal of Mental Health, 10*(2), 223-235.

Reinecke, M. A., & Davidson, M. R. (Eds). (2002). *Comparative treatments of depression.* NY: Springer Publishing Company, Inc.

Ritchie, J., & Ritchie, J. (1999). Seventy-five years of cross-cultural psychology in New Zealand. In W. J. Lonner, D. L. Dinnel, D. K. Forgays, & S. A. Hayes (Eds.), *Merging past, present, and future in cross-cultural psychology: Selected papers from the fourteenth international congress of the international association for cross-cultural psychology* (pp. 105-115). The Netherlands: Swets & Zeitlinger.

Roberts, A. R. & Yeager, K. R. (Eds). (2004). *Evidence-based practice manual: Research and outcome measures in health and human services.* New York: Oxford University Press

Samion, S. (1999). *Counsellees' perceptions of their therapeutic alliance with traditional healers.* Unpublished master's thesis. National Institute of Education, Nanyang Technological University, Singapore.

Sandhu, D. S. (Ed.). (1999). *Asian and Pacific Islander Americans: Issues and concerns for counselling and psychotherapy.* New York: Nova Science.

Sandhu, D. S., Kaur, K. P., & Tewari, N. (1999). Acculturative experiences of Asian and Pacific Islander Americans: Considerations for counseling and psychotherapy. In D. S. Sandhu (Ed.), *Asian and Pacific Islander Americans: Issues and concerns for counselling and psychotherapy* (pp. 3-19). New York: Nova Science.

Sartorius, N., Ustun, T. B., Silva, J.-A. C. E., Goldberg, D., Lecrubier, Y., Ormel, J., et al. (1993). An international study of psychological problems in primary care: Preliminary report from the World Health Organization collaborative project on "psychological problems in general health care". *Archives of General Psychiatry, 50*(10), 819-824.

Sbrana, A., Dell'Osso, L., Gonnelli, C., Impagnatiello, P., Doria, M. R., Spagnolli, S., et al. (2003). Acceptability, validity and reliability of the structured clinical interview for the spectrum of substance use (SCI-SUBS): A pilot study. *International Journal of Methods in Psychiatric Research, 12*(2), 105-114.

Shafi, S. (1998). A study of Muslim Asian women's experiences of counselling and the necessity for a racially similar counsellor. *Counselling Psychology Quarterly, 11*(3), 301-314.

Shams, M. (2002). Issues in the study of indigenous psychologies: Historical perspectives, cultural interdependence and institutional regulations. *Asian Journal of Social Psychology, 5*(2), 79-91.

Sheikh, S., & Furnham, A. (2000). A cross-cultural study of mental health beliefs and attitudes towards seeking professional help. *Social Psychiatry and Psychiatric Epidemiology, 35*(7), 326-334.

Shin, S.-M., Chow, C., Camacho-Gonsalves, T., Levy, R. J., Allen, I. E., & Leff, H. S. (2005). A meta-analytic review of racial-ethnic matching for African American and Caucasian American clients and clinicians. *Journal of Counseling Psychology, 52*(1), 45–56.

Shobhadevi, Y. J., & Bidarakoppa, G. S. (1994). Possession phenomena: As a coping behaviour. In G. Davidson (Ed.), *Applying psychology: Lessons from Asia-Oceania* (pp. 83-95). Brisbane, Australia: Australian University Press.

Sim, T. (1999). Development of counselling service in Singapore. *Asian Journal of Counselling, 6*(2), 49-75.

Singapore Association of Social Workers. (2004, May 12). *Registered social worker (RSW) online register available now*. Retrieved June 21, 2004, from http://www.sasw.org.sg

Singapore Medical Association. (2003). *Membership.* Retrieved June 21, 2004, from http://www.sma.org.sg/membership/

Singapore Psychological Society. (2004). *SPS membership directory*. Retrieved June 21, 2004, from http://singaporepsychologicalsociety.org/memdir.html

Slavet, J. D., Parker, L., Kitowicz, J. M., & MacDonald, M. L. (2000). *Stigma of psychotherapy: It's not ok to get help*. Amherst, MA: University of Massachusetts.

Smith, D. P., & Orlinsky, D. E. (2004). Religious and spiritual experience among psychotherapists. *Psychotherapy: Theory, Research, Practice, Training, 41*(2), 144–151.

Soffe, J., Read, J., & Frude, N. (2004). A survey of clinical psychologists' views regarding service user involvement in mental health services. *Journal of Mental Health, 13*(6), 583–592.

Somekh, B., & Lewin, C. (Eds.). (2005). *Research methods in the social sciences.* London: SAGE publications.

Soong, C. F. H. (1997). *Adaptation of western counselling approaches to an Asian multicultural context*. Unpublished doctoral thesis. National Institute of Education, Nanyang Technological University, Singapore.

Sorenson, R. L. (1994). Therapists' (and their therapists') god representations in clinical practice. *Journal of Psychology and Theology, 22*(4), 325-344.

Spitzer, R. L., Williams, J. B., Gibbon, M., & First, M. B. (1992). The structured clinical interview for DSM-III-R (SCID). I: History, rationale, and description. *Archives of General Psychiatry, 49*(8), 624-629.

Statistics New Zealand (2006). *QuickStats National Highlights*. Retrieved January 13, 2007 from http://www.stats.govt.nz/census/2006-census-data/national-highlights/2006-census-quickstats-national-highlights.htm?page=para006Master

Statistics Singapore (2006). *Singapore total population*. Singapore Department of Statistics. Retrieved January 13, 2007 from http://www.singstat.gov.sg/keystats/annual/indicators.html

Steinberg, M., & Hall, P. (1997). The SCID-D diagnostic interview and treatment planning in dissociative disorders. *Bulletin of the Menninger Clinic, 61*(1), 108-120.

Stewart, T. R. (1995). *Ka pu te ruha, ka hao te rangatahi: Contributions to 'indigenous psychology' in Aotearoa/New Zealand*. Unpublished masters thesis. University of Auckland, Auckland, New Zealand.

Sue, D. W., & Sue, D. (1999). *Counselling the culturally different: Theory and practice* (3rd ed.). New York: John Wiley.

Sue, D. W., & Sue, D. (2003). *Counselling the culturally diverse: Theory and practice* (4th ed.). New York: John Wiley.

Tantam, D., van Deurzen, E., & Osterloh, K. (2001). The Survey of European Psychotherapy Training 2: Questionnaire data. *The European Journal of Psychotherapy, Counselling & Health, 4*(3), 379–395.

Tassell, N. A. (2004). *Workforce profile II: A further analysis of the Māori mental health workforce*. Palmerston North, New Zealand: Te Rau Matatini.

Taufa, P. A. (1996). *The cultural dimension of professional training and practice in psychology*. Unpublished masters thesis. University of Auckland, Auckland, New Zealand.

Taylor, G. R. (2000). *Integrating quantitative and qualitative methods in research*. NewYork: Oxford University Press of America.

Thakker, J., Ward, T., & Strongman, K. T. (1999). Mental disorder and cross-cultural psychology: A constructivist perspective. *Clinical Psychology Review, 19*(7), 843-874.

The Treasury. (2006). *New Zealand: Area and population.* Wellington, New Zealand: The Treasury. Retrieved May 2, from http:www//thetreasury.govt.nz

Thomas, E. (1990). Filial piety, social change and Singapore youth. *Journal of Moral Education, 19*(3), 192-204. Retrieved September 29, 2001, from the EBSCO*host* Academic Search Elite database.

Thorne, B. (2000). Religion and secular assumptions. In C. Feltham, & I. Horton (Eds.), *Handbook of counselling and psychotherapy* (pp. 57-61). London: Sage.

Todd, Z., Nerlich, B., & McKeown, S. (2004). Introduction. In Z. Todd, B. Nerlich, S. McKeown & D. D. Clarke (Eds.), *Mixing methods in psychology: The integration of qualitative and quantitative methods in theory and practice* (pp. 3-16). New York: Psychology Press.

Tofi, T. A. (1996). *The use of health care services by Pacific islands people in New Zealand.* Unpublished master's thesis. Massey University, Palmerston North, New Zealand.

Tse, S., Bhui, K., Thapliyal, A., Choy, N., & Bray, Y. (2005). *Asian mental health workforce development: Educational programme. Prepared for Research Council of New Zealand.* University of Auckland, New Zealand: Auckland UniServices Limited.

Tseng, W.-S., Ebata, K., Kim, K.-I., Krahl, W., Kua, E. H., Lu, Q., et al. (2001). Mental health in Asia: Social improvements and challenges. *International Journal of Social Psychiatry, 47*(1), 8-23.

Van Deurzen, E. (2001). Psychotherapy training in Europe: Similarities and differences. *The European Journal of Psychotherapy, Counselling & Health, 4*(3), 357–371.

Vicary, D., & Andrews, H. (2000). Developing a culturally appropriate psychotherapeutic approach with indigenous Australians. *Australian Psychologists, 35*(3), 181-185.

Waldegrave, C., Tamasese, K., Tuhaka, F., & Campbell, W. (2003). *Just therapy: A journey: A collection of papers from the Just Therapy Team, New Zealand.* Adelaide, S. Australia: Dulwich Centre Publications.

Walker, R., Wu, C. W. D., Soothi-O-Soth, M., & Parr, A. (1998). *New Zealand's Asian population: Views on health and health services.* Auckland, New Zealand: Health Funding Authority.

Wallach, H. S., & Farbshtein, I. (2001). Reliability and validity of the translated psychotherapy expectancy inventory. *The Israel Journal of Psychiatry of Related Sciences, 38*(2), 115-122.

Walsh, R. (1995). Asian psychotherapies. In R. J. Corsini, & D. Wedding (Eds.), *Current psychotherapies* (5th ed., pp. 387-398). Itasca, IL: F. E. Peacock.

Wan Mahmud, W. M. R., Awang, A., Herman, I., & Mohamed, M. N. (2004). Analysis of the psychometric properties of the Malay version of Beck Depression Inventory II (BDI-II) among postpartum women in Kedah, north west of peninsular Malaysia. *Malaysian Journal of Medical Sciences, 11*(2), 19-25.

Ward, C. (1999). Models and measurements of acculturation. In W. J. Lonner, D. L. Dinnel, D. K. Forgays, & S. A. Hayes (Eds.), *Merging past, present, and future in cross-cultural psychology: Selected papers from the fourteenth international congress of the international association for cross-cultural psychology* (pp. 221-230). The Netherlands: Swets & Zeitlinger.

Wedding, D. (1995). Current issues in psychotherapy. In R. J. Corsini, & D. Wedding (Eds.), *Current psychotherapies* (5th ed., pp. 419-432). Itasca, IL: F. E. Peacock.

Weissman, M. M., Bland, R. C., Canino, G. J., Faravelli, C., Greenwald, S., Hwu, H., et al. (1997). The cross-national epidemiology of panic disorder. *Archives of General Psychiatry, 54*(4), 305-309.

Wells, A. (1997). *Cognitive therapy of anxiety disorders: A practical manual and conceptual guide.* Chichester, England: John Wiley & Sons.

West, W. (1997). Integrating counselling, psychotherapy and healing: An inquiry into counsellors and psychotherapists whose work includes healing. *British Journal of Guidance and Counselling, 25*(3), 291-311.

Whaley, A. L. (2001). Cultural mistrust and mental health services for African Americans: A review and meta-analysis. *Counseling Psychologist, 29*(4), 513-531.

Williams, M., May, T., & Wiggins, R. D. (1996). *Introduction to the philosophy of social research.* London: UCL Press.

Williams, M. W., Foo, K. H., & Haarhoff, Beverly. (2006). Cultural considerations in using cognitive behaviour therapy with Chinese people: A case study of an elderly Chinese woman with generalised anxiety disorder. *New Zealand Journal of Counselling, 35*(3), 153-162.

Williams, M. W., Graham, E. Y. H., & Foo, K. H. (2004). A modified cognitive behavioural therapy model for working with Chinese people. In S. Tse, A. Thapliyal, S. Garg, G. Lim, & M. Chatterji, *Proceedings of the inaugural international Asian health conference: Asian health and wellbeing, now and into the future* (pp. 209-222). New Zealand: The University of Auckland, School of Population Health.

Wintersteen, M. B., Mensinger, J. L., & Diamond, G. S. (2005). Do gender and racial differences between patient and therapist affect therapeutic alliance and treatment retention in adolescents? *Professional Psychology: Research and Practice, 36*(4), 400–408.

Wong, C.-W. (2006, May). The consolidation of evidence based psychological treatments in Hong Kong. In G. Yiu (Chair), *Teaching of CBT in Hong Kong and China.* Symposium conducted at the conference of the 1st Asian Cognitive Behaviour Therapy (CBT) Conference: Evidence-based Assessment, Theory & Treatment, The Chinese University of Hong Kong, Hong Kong.

Wong, S. (2001, August 30). *Asian mental health forum: Issues and concerns.* Auckland, New Zealand: Asian Health Support Service, Waitemata District Health Board.

Wong, L. C. J., Ishiyama, F. I., & Wong, P. T. P. (1999). Exploring the world of meaning of ESL students. In W. J. Lonner, D. L. Dinnel, D. K. Forgays, & S. A. Hayes (Eds.), *Merging past, present, and future in cross-cultural psychology: Selected papers from the fourteenth international congress of the international association for cross-cultural psychology* (pp. 473-485). The Netherlands: Swets & Zeitlinger.

Woolfe, R., Dryden, W., & Strawbridge, S. (2003). *Handbook of counselling psychology* (2nd ed.). London: Sage.

Yan, M. C., & Lam, C. M. (2000). Repositioning cross-cultural counseling in a multicultural society. *International Social Work, 43*(4), 481-493.

Yang, K.-S. (2000). Monocultural and cross-cultural indigenous approaches: The royal road to the development of a balanced global psychology. *Asian Journal of Social Psychology, 3*, 241-263.

Yates, S. J. (2004). *Doing social science research*. SAGE Publications.

Yeh, C. J., Inman, A. G., Kim, A. B., & Okubo, Y. (2006). *Cultural diversity and ethnic minority psychology, 12*(1), 134–148.

Yeo, A. (1993). Counselling in Singapore: Development and trends. In A. H. Othman & A. Awang (Eds.), *Counselling in the Asia Pacific region* (pp. 27-39). London: Greenwood Press.

Yeo, C. (2004). Mind your Mind: A preventive programme for the control of major mental disorders in Singapore. In S. Saxena & P. J. Garrison, *Mental Health Promotion: Case Studies from Countries.* A Joint Publication of the World Federation for Mental Health and the World Health Organization.

Young, J. E. (1999). *Cognitive therapy for personality disorders: A schema focused approach* (3rd ed.). FL: Professional Resource Press.

Young, M. E. (1993). Theoretical trends in counselling: A national survey. *Guidance & Counseling, 9*(1), 4-9.

Zane, N., Sue, S., Chang, J., Huang, L., Huang, J., Lowe, S., et al. (2005). Beyond ethnic match: Effects of client-therapist cognitive match in problem perception, coping orientation, and therapy goals on treatment outcomes. *Journal of Community Psychology, 33*, 569-585.

Zerbetto, R. & Tantam, D. (2001). The survey of European psychotherapy training 3: What psychotherapy is available in Europe? *The European Journal of Psychotherapy, Counselling & Health, 4*(3), 397–405.

Zinnbauer, B. J., & Pargarment, K. I. (2000). Working with the sacred: Four approaches to religious and spiritual issues in counseling. *Journal of Counseling and Development, 78*(2), 162-171.

APPENDIX A

COMPARING THERAPIST SKILLS

New Zealand and Singapore

A SURVEY

This survey, done in partial fulfilment of my doctoral thesis at Massey University, New Zealand, will produce findings about the *similarities* and *differences* of therapy skills between New Zealand and Singapore therapists that could benefit you and others in the field of therapy.

Please complete the following questions. If you wish to comment on any questions or qualify your answers, please use the space provided on the back cover.

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- Therapists **refer to clinicians or practitioners of counselling or psychotherapy.**
- Therapy skills **refer to both counselling and psychotherapy skills.**
- Self-disclosure **refers to instances in therapy where you were asked to reveal personal details like age, marital status, number of children, experience, religion, and personal opinions and feelings of issues in questions, etc.**

A. THERAPIST BACKGROUND

A1. Gender (*tick as appropriate*)

- **Male** ☐
- **Female** ☐

A2. Age *(tick as appropriate)*

- **20-30** ☐
- **31-40** ☐
- **41-50** ☐
- **Over 51** ☐

A3. Ethnicity (*tick as appropriate*)

- **Caucasian (Pakeha)** ☐
- **Chinese** ☐
- **Indian** ☐
- **Japanese** ☐
- **Korean** ☐
- **Malay** ☐
- **Māori** ☐
- **Pacific Islander** ☐ **(specify)**_____
- **Other (specify)**_____

A4. Language abilities (*tick as appropriate)*

- **Chinese** ☐
- **English** ☐
- **French** ☐
- **German** ☐
- **Malay** ☐
- **Tamil** ☐
- **Te Reo Māori** ☐
- **Others (specify)**_____

A5. Religious affiliation (optional) (*tick as appropriate*)

- **Buddhist** ☐
- **Christian** ☐
- **Hindu** ☐
- **Māori Whakapono** ☐
- **Muslim** ☐
- **Taoist** ☐
- **None** ☐
- **Other (specify)**_____

A6. Employment status (*tick as appropriate*)

- **Government Sector** ☐
- **Private Sector** ☐
- **Self-employed** ☐

A7. Primary job affiliation *(tick as appropriate)*

- **Counsellor** ☐
- **General Practitioner** ☐
- **Psychiatrist** ☐
- **Psychologist** ☐
- **Psychotherapist** ☐
- **Social Worker** ☐
- **Other specify)**_____

A8. Primary work setting (*tick as appropriate*)

- **In-patient** ☐
- **Out-patient/Community** ☐
- **Private Practice** ☐
- **Training** ☐
- **Other (specify)**_____

_____

_____

_____

A9. Focus of practice (*tick as appropriate)*

- **Children** ☐
- **Adolescents** ☐
- **Adults** ☐
- **Geriatrics** ☐
- **Other (specify)**_____

_____

_____

_____

A10. On what basis do you choose the therapy you most currently use?

B. THERAPIST TRAINING

B1. Country or countries trained in
(tick as appropriate)

- **Australia** ☐
- **Canada** ☐
- **New Zealand** ☐
- **Singapore** ☐
- **United Kingdom** ☐
- **USA** ☐
- **Others (specify)**_____

B2. Qualification(s) in therapy
(tick and fill out as appropriate)

		Please specify:
Certificate	☐	_____
Diploma	☐	_____
Bachelor's Degree	☐	_____
Masters Degree	☐	_____
Doctoral Degree	☐	_____
PostGrad Diploma	☐	_____

Others (specify) _____

B3. Institution/Organisation qualification(s) obtained from:

B4. Number of years of supervised training.
(enter number in box)

☐

B5. Registration (NZ only)
(tick as appropriate)

Yes ☐ **No** ☐

B6. Years of experience in therapy
(tick as appropriate)

- **1 to 5** ☐
- **6 to 10** ☐
- **11 to 15** ☐
- **16 to 20** ☐
- **21 to 25** ☐
- **26 to 30** ☐
- **Over 30** ☐

B7. To what extent is your practice guided by the following basic therapy models?

1----------2----------3----------4----------5
mostly **not at all**
(enter number on line)

- **Alderian** _____
- **Behavioural** _____
- **Cognitive** _____
- **Eclectic/Integrative** _____
- **Existential** _____
- **Experiential** _____
- **Gestalt** _____
- **Humanistic** _____
- **Interpersonal** _____
- **Psychoanalytic/Psychodynamic** _____
- **Rogerian** _____

Other (specify)_____

B8. To what extent are the basic therapy models relevant to your ethnic clients?

1----------2----------3----------4----------5
mostly **not at all**
(enter number on line)

- **Caucasian** _____
- **Chinese** _____
- **Indian** _____
- **Koreans** _____
- **Japanese** _____
- **Malay** _____
- **Māori** _____
- **Pacific Islander** _____
- **Others (specify)** _____

C. CLIENTELE

C1. Estimate percentage of clients seen in past year (2001).
(*enter percentage on line*)

	0-100 %
Caucasian (Pakeha)	_____
Chinese	_____
Indian	_____
Japanese	_____
Koreans	_____
Malay	_____
Māori	_____
Pacific Islander	_____
Others (specify)	_____

C2. Estimate clients' presenting problems in past year (2001).
(*enter percentage on line*)

	0-100 %
Alcohol Abuse	_____
Anxiety	_____
Attention Deficit Disorder	_____
Autism	_____
Behavioural Problems	_____
Bipolar Disorder	_____
Dementia	_____
Eating Disorders	_____
General Anxiety Disorder	_____
Major Depression	_____
Marital Problems	_____
Obsessive-compulsive Disorders	_____
Panic Disorder	_____
Personality Problems	_____
Phobias	_____
Schizophrenia	_____
Sexual Disorders	_____
Substance Abuse	_____
Others (specify)	_____

_____

_____

_____

_____

D. DIAGNOSTIC SYSTEM

D1. What is your basic diagnostic system?
(*tick as appropriate*)

DSM IV	☐
ICD 10	☐
Other (specify)	_____

D2. To what extent do you use the diagnostic system with the following list of clients?

1----------2----------3----------4----------5
often **not at all**
(*enter number on line*)

Caucasian (Pakeha)	_____
Chinese	_____
Indian	_____
Japanese	_____
Koreans	_____
Malay	_____
Māori	_____
Pacific Islander	_____
Others (specify)	_____

D3. How often do you use the following diagnostic tools? (*enter number on line*)

1----------2----------3----------4----------5
very frequent **not at all**
(*enter number on line*)

a. Projective Assessment Procedures

Draw-a-person	_____
Rorschach	_____
Sentence Completion Methods	_____
TAT	_____
Others (specify)	_____

b. Objective Assessment Procedures

Raven's Progressive Matrices	_____
Stanford-Binet IV	_____
Wechsler Intelligence Scales	_____
Anxiety/Depression Inventories	_____
Neurological Tests	_____
STAI	_____
WMS	_____
SCL-90	_____
16PF	_____
MMPI-2	_____
MCMI	_____
Others (specify)	_____

_____

_____

_____

_____

_____

_____

D4. Estimate percentage of time that you practise the following interventions in therapy.
(*enter percentage on line*)

0-100 %

Behavioural Management _____
Brief Therapy _____
Cognitive Therapy _____
Cognitive-Behavioural Therapy _____
Emotion-focused Therapy _____
Family Therapy _____
Marital Therapy _____
Narrative Therapy _____
Psycho-education _____
Relaxation _____
Stress Management _____
System Therapy _____
Others (specify)_____

D5. Average number of sessions per client
(*enter number in box*)

☐

E. SPECIAL ISSUES (optional)

E1. How do you handle self-disclosure?

E2. How do you handle clients who want to involve religious issues in therapy?

E3. Therapists sometimes encounter clients who may request the same gender or ethnic group therapist for the therapy sessions.

a. How often have you encountered such requests? (*enter number in box*)

1----------2----------3----------4----------5
often **not at all**

☐

b. Reason(s) for such requests:

E4. Would you object to a traditional healer working with your client?
(*tick as appropriate*)

Yes ☐ **No** ☐

If no, would you allow a traditional healer to work alongside you in therapy?

Yes ☐ **No** ☐

Any comment on this?

E5. How culturally appropriate are therapy practices in your country? (*enter number in box*)

1----------2----------3----------4----------5
very appropriate **not at all**

☐

Comments: ---

Please turn to back cover of questionnaire

If you have any comments you would like to make about this survey, of therapy skills, please write them on this page.

Your contribution to this survey is very greatly appreciated. Please return your questionnaire in the reply paid envelope provided. If the envelope has been mislaid, please forward to:

Foo, Koong Hean
School of Psychology
Building 46
Massey University
Albany Campus
Private Bag 102-904
North Shore MSC
Auckland, New Zealand
Email address: fookoonghean@yahoo.com.sg

A copy of the report completed from this survey will be sent to all participants upon request.

[*Note*: The size of questionnaire has been adjusted to fit the thesis page format.]

APPENDIX B

Questions for Structured Interview

Interviewee Particulars

Name:_____ Male/Female Age_____
Ethnicity_____ Language used_____
Primary Job Affiliation_____ Private/Public
Work Place_____

Structured Interview Questions

1. Could you tell me about your training in counselling or psychotherapy? Which country trained in? Counselling/Psychotherapy/Both Length of training (including supervision) Qualification or title Orientation to therapy? Are you registered? (NZ only) Years of experience in counselling or psychotherapy Focus of therapy (child/adolescent/adults/geriatrics) Your preference to therapy? The fees you charged per session?
2. What is your opinion of the efficacy of Westernised counselling or psychotherapy? Efficacy Suitability Modification Culture-specific
3. Is there an indigenous counselling or psychotherapy model? Describe Strengths Weaknesses Applicability
4. What are your views of traditional therapies like herbal medicine, acupuncture, prayers, etc? Comparability Efficacy Suitability Culture-specific
5. What are your views of "modern therapies" like aromatherapy, massage therapy, meditation, etc? Comparability Efficacy Suitability Culture-specific
6. Could you provide a profile of your clients? Age Range Gender Ethnicity Types of problems Perception and attitude towards therapy Beliefs Preferences Self-disclosure
7. Do you use a diagnostic system in therapy? DSM IV/ICD 10 Others Reasons for use
8. Do you also use diagnostic tools like psychological tests? Describe Frequency Reasons for use
9. What is your view of religion or spirituality in therapy? Roles of religion in therapy, if any Suitability In conjunction with religious healers
10. Other comments (if any)

APPENDIX C

Massey University
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Comparative study examining the therapy skills between counsellors/psychotherapists of New Zealand and Singapore

INFORMATION SHEET FOR CLINICIANS (MAIL QUESTIONNAIRE)

My name is Foo, Koong Hean and I am completing a doctoral degree in psychology at Massey University. My supervisor is Paul Merrick, Associate Professor, School of Psychology, who is based at Massey University, Albany, New Zealand.

This study compares the therapy skills between counsellors/psychotherapists of New Zealand and Singapore. The overall aim of the study is to look for similarities and differences of therapy skills that will benefit the practice of therapy in both these countries.

To achieve my goal I require input from clinicians of both New Zealand and Singapore, particularly those in the mental health services. I have used institutional listings (e.g. GM Resource and Referral Directory, New Zealand Psychologists Board, New Zealand College of Clinical Psychologists, and New Zealand Yellow Pages; and the Directory of Social Services, the Community of Mental Health Directory, and Yellow Pages from Singapore) and Internet websites to contact you and invite you to participate in this study.

This study will involve approximately 20 minutes of your time and will require you to complete the attached questionnaire and return it to me in the envelope provided. Please be aware that the questionnaire contains questions personal to your training and experience in therapy.

Completion and return of the questionnaire implies that your consent to participate in this study. You have the right to decline to answer any particular question.

Any information you provide will be anonymous and your reply will not be identified as yours in any way. Only the researcher and supervisor will see the raw data. At the conclusion of the study all returned questionnaires will be held for a period of 5 years and then destroyed. The final research reports will present aggregated data only therefore confidentiality will be preserved.

If you have any questions about the interview, or would like to discuss it, please contact either Prof. Paul Merrick (P.L.Merrick@massey.ac.nz) or me (fookoonghean@yahoo.com.sg) at the addresses stated.

This project has been reviewed and approved by the Massey University Human Ethics Committee. If you have any concerns about the conduct of this research, please contact Sylvia Rumball, Chair, Human Ethics Committee: Palmerston North, telephone (06) 3505249, email S.V.Rumball@massey.ac.nz.

Regards

Foo, Koong Hean
Researcher

APPENDIX D

Letter to Organisation on Questionnaire Survey

Massey University
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Private Bag 102904
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The Clinical Director

Dear Sir/Madam,

Re: Questionnaire Survey

I am Foo, Koong Hean currently studying for the PhD in psychology at Massey University, Albany, New Zealand.

My research looks at the similarities and differences in therapy skills between Singapore and New Zealand therapists. In order to do that, questionnaire surveys of counsellors/psychotherapists are to be carried out.

I would really appreciate it if members of your organization could take part in this survey.

Attached are _____ copies of the questionnaire titled *Comparing Therapy Skills* for counsellors/psychotherapists. Attached to each questionnaire are an Information Sheet (for Clinicians) and a freepost return envelope.

I would appreciate very much if you could distribute them to your clinicians (psychiatrists, clinical psychologists, counsellors, psychotherapists, or social workers) to be filled out individually and returned to me at their earliest convenience.

Please contact me through my mobile (021 160 3465) or through my email address (fookoonghean@yahoo.com.sg) for clarification.

Thank you and regards.

Foo, Koong Hean (Mr.)
Researcher
Date:

APPENDIX E

Follow-up Letter to Organisation

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Re: Questionnaire Survey

Four weeks ago a set of questionnaires seeking input from counsellors/psychotherapists and clients about their personal opinions on therapy in New Zealand/Singapore was mailed to you.

If you have already completed and returned it to me, or distributed them to your counsellors, psychotherapists and clients, please accept my sincere thanks. If not, I would appreciate it if you could do so today. It is extremely important that data about your opinions on therapy be included in the study if the results are to accurately represent the therapists' opinions in New Zealand/Singapore, as compared to Singaporeans'/New Zealanders'.

If by some chance you did not receive the questionnaire, or it has been misplaced, please contact me at New Zealand's number 0064 021 1603465 or email me at fookoonghean@yahoo.com.sg and I will send another one immediately.

Yours sincerely

Foo Koong Hean (Mr)
Researcher
Date:

APPENDIX F

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Comparative study examining the therapy skills between counsellors/psychotherapists of New Zealand and Singapore

INFORMATION SHEET FOR CLINICIANS (INTERVIEW)

My name is Foo, Koong Hean and I am completing a doctoral degree in psychology at Massey University. My supervisor is Paul Merrick, Associate Professor, School of Psychology, who is based at Massey University, Albany, New Zealand.

This study compares the therapy skills between counsellors/psychotherapists of New Zealand and Singapore. The overall aim of the study is to look for similarities and differences of therapy skills that will benefit the practice of therapy in both these countries.

To achieve my goal I require input from clinicians of both New Zealand and Singapore, particularly those in the mental health services. I have used institutional listings (e.g. GM Resource and Referral Directory, New Zealand Psychologists Board, New Zealand College of Clinical Psychologists, and New Zealand Yellow Pages; and the Directory of Social Services, the Community of Mental Health Directory, and Yellow Pages from Singapore) and Internet websites to contact you and invite you to participate in this study.

This study will involve approximately 30-60 minutes of your time and will require you to do a face-to-face interview with the researcher at a location of your convenience. The interview will be audiotaped.

Only the researcher and supervisor will have contact with the raw data. At the conclusion of the study all audiotapes will be held for a period of 5 years and then destroyed. The final research reports will present aggregated data only therefore confidentiality will be preserved.

If you have any questions about the interview, or would like to discuss it, please contact either Prof. Paul Merrick (P.L.Merrick@massey.ac.nz) or me (fookoonghean@yahoo.com.sg) at the addresses stated.

This project has been reviewed and approved by the Massey University Human Ethics Committee. If you have any concerns about the conduct of this research, please contact Sylvia Rumball, Chair, Human Ethics Committee: Palmerston North, telephone (06) 3505249, email S.V.Rumball@massey.ac.nz.

Regards

Foo, Koong Hean
Researcher

APPENDIX G

Massey University
COLLEGE OF HUMANITIES AND SOCIAL SCIENCES

SCHOOL OF PSYCHOLOGY
Private Bag 102 904
North Shore MSC
Auckland
New Zealand
T 64 9 414 0800 extn 9180
F 64 9 441 8157
www.massey.ac.nz

Comparative study examining the therapy skills between counsellors/psychotherapists of New Zealand and Singapore

CONSENT FORM

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand I have the right to withdraw from the study at any time and to decline to answer any particular questions.

I agree to provide information to the researcher on the understanding that my name will not be used without my permission.
(*The information will be used only for this research and publications arising from this research project*).

I agree/do not agree to the interview being audio taped.

I also understand that I have the right to ask for the audio tape to be turned off at any time during the interview.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signed: .....

Name: .....

Date: .....

APPENDIX H

Sample of Inter-rater Reliability Study

Massey University
COLLEGE OF HUMANITIES AND SOCIAL SCIENCES

SCHOOL OF PSYCHOLOGY
Private Bag 102 904
North Shore MSC
Auckland
New Zealand
T 64 9 414 0800 extn 9180
F 64 9 441 8157
www.massey.ac.nz

Dear participant,

My name is Foo, Koong Hean and I am completing a doctoral degree in psychology at Massey University. My supervisor is Associate Professor Paul Merrick, who is based at the School of Psychology, Massey University, Albany Campus, New Zealand.

My study compares practitioner characteristics and practices between New Zealand and Singapore mental health practitioners. An important part of the methodology is the categorisation of responses in the content analysis being evaluated. I would like to ask of you to assist with this brief task. I have chosen the area of practitioner self-disclosure for this task.

Thank you for participating in the task. Appended below are the practitioners' verbatim comments from New Zealand and Singapore on the topic of self-disclosure. Your task is to read these comments and rate them on a Likert Scale of 1 to 5; 1 being not self-disclosing at all, to 5 being high self-disclosing. Please also include your comments on the sub-topic of self-disclosure; specifically if there are themes found among the practitioners' comments.

Only the researcher and supervisor will see the raw data. Please do not hesitate to contact me should you have any queries regarding this study. My email address is fookoonghean@yahoo.com.sg Alternatively, Paul Merrick can be contacted on telephone (0064 09) 4140800 ext. 9865 or by email at P.L.Merrick@massey.ac.nz

Regards

Foo, Koong Hean
Researcher
Date:

Definition:

Self-disclosure is defined as practitioners' statements that reveal facts about themselves and personal experiences in their own lives.

A *theme* is defined as a specific and distinctive quality.

Rating: Amount of self-disclosure

1----------	**2**----------	**3**----------	**4**----------	**5**
not self-disclosing at all	low self-disclosing	moderate self-disclosing	above moderate self-disclosing	high self-disclosing

Example:

Practitioner's Comments	**Rating Self-disclosure**	**Your Comments (themes, if any)**
"I tell clients about my professional qualifications only".	Is the statement about self-disclosure? (Yes) No If Yes, rate amount of self-disclosure: 1-----(2)-----3-------4-------5	[An overview of some or all comments] Practitioners would use self-disclosure as part of therapy.

Comments from New Zealand participants on practitioners' self-disclosure

1----------2----------3----------4----------5

not self-disclosing at all	low self-disclosing	moderate self-disclosing	above moderate self-disclosing	high self-disclosing

New Zealand Practitioner's Comments	Rating Self-disclosure	Your Comments (themes, if any)
"Clients may ask about my disability; ...stick to interpretation of therapy. Depends on issues discussed when questions are asked...for example, on gambling, ...asked if I am married, ...would ask relevance from clients? ...think that clients prefer ...clinician speaks from academic and practical knowledge".	Is the statement about self-disclosure? Yes No If Yes, rate amount of self-disclosure: 1-------2-------3-------4-------5	
"Normally...have a bit to get people at ease.... Limited self-disclosure".	Is the statement about self-disclosure? Yes No If Yes, rate amount of self-disclosure: 1-------2-------3-------4-------5	
"...disclose to certain degree because it is significant or useful to them, ...some sharing".	Is the statement about self-disclosure? Yes No If Yes, rate amount of self-disclosure: 1-------2-------3-------4-------5	
"...professional information as advertised on university's website. In private practice, clients with doubts can ask anything".	Is the statement about self-disclosure? Yes No If Yes, rate amount of self-disclosure: 1-------2-------3-------4-------5	

1----------2----------3----------4----------5

not self-disclosing at all	low self-disclosing	moderate self-disclosing	above moderate self-disclosing	high self-disclosing

New Zealand Practitioner's Comments	Rating Self-disclosure	Your Comments (themes, if any)
"Working in mainstream, ...is discouraged from disclosing therapist selves; but with Chinese, ...important to do some self-disclosure...builds rapport faster. For example, A*s a migrant too*.... Self-disclosure has therapeutic effect."	Is the statement about self-disclosure? Yes No If Yes, rate amount of self-disclosure: 1-------2-------3-------4-------5	
"Quite frequently. ...tell clients enough to be polite, to build rapport as well".	Is the statement about self-disclosure? Yes No If Yes, rate amount of self-disclosure: 1-------2-------3-------4-------5	
"...being asked after working with...client for long time, say often 2 years. ...an important part of a relationship. If beneficial to client, ...self-disclose quite a bit".	Is the statement about self-disclosure? Yes No If Yes, rate amount of self-disclosure: 1-------2-------3-------4-------5	
"...because dealing with young people, need to push boundary a bit more ...because ...expect young people to talk about their innermost stuff is really difficult, ...so prepared to self-disclose a little bit, in small appropriate amounts".	Is the statement about self-disclosure? Yes No If Yes, rate amount of self-disclosure: 1-------2-------3-------4-------5	

1----------2----------3----------4----------5

not self-disclosing at all	low self-disclosing	moderate self-disclosing	above moderate self-disclosing	high self-disclosing

New Zealand Practitioner's Comments	Rating Self-disclosure	Your Comments (themes, if any)
"Often self-disclose if useful, or offer example from own life to explain a point or gain some rapport with client …because of the belief that the client comes and shares very personal information. For example, *I remember when I had a fight with my father….* Clinician… more human and personal. …break rules especially with teenagers…can't sit there with clipboard. Some clinical psychologists stick to essence of model…make it comfortable for person".	Is the statement about self-disclosure? Yes No If Yes, rate amount of self-disclosure: 1-------2-------3-------4-------5	
"…use self-disclosure to join with people, or sometimes to normalise some of the difficulties they go through… makes it more human…actually joined together and take a journey".	Is the statement about self-disclosure? Yes No If Yes, rate amount of self-disclosure: 1-------2-------3-------4-------5	
"…probably an age thing…people are very respectful, very grateful to be seen by a doctor; …ask personal questions from psychiatrist…depends on question or stage of therapy or help".	Is the statement about self-disclosure? Yes No If Yes, rate amount of self-disclosure: 1-------2-------3-------4-------5	

Comments from Singapore participants on practitioners' self-disclosure (SD)

1----------2----------3----------4----------5

not self-disclosing at all	low self-disclosing	moderate self-disclosing	above moderate self-disclosing	high self-disclosing

Singapore Practitioner's Comments	Rating Self-disclosure	Your Comments (themes, if any)
"Not a problem. Clients like to know professional background…try to find therapist out indirectly before meeting. Some not aware of social barriers".	Is the statement about self-disclosure? Yes No If Yes, rate amount of self-disclosure: 1-------2-------3-------4-------5	
"…use some self-disclosure in counselling. For example, use personal experience to talk with low self-esteem, inferior adolescent. Hence, some self-disclosure is helpful".	Is the statement about self-disclosure? Yes No If Yes, rate amount of self-disclosure: 1-------2-------3-------4-------5	
"…will tell clients my religion is Christianity…feel adequate by telling client about self…pre-empt with introduction. Basically professional information".	Is the statement about self-disclosure? Yes No If Yes, rate amount of self-disclosure: 1-------2-------3-------4-------5	
"…don't mind telling …I am Catholic if asked".	Is the statement about self-disclosure? Yes No If Yes, rate amount of self-disclosure: 1-------2-------3-------4-------5	

1----------2----------3----------4----------5

not self-disclosing at all	low self-disclosing	moderate self-disclosing	above moderate self-disclosing	high self-disclosing

Singapore Practitioner's Comments	**Rating Self-disclosure**	**Your Comments (themes, if any)**
"...clients would ask when they get to know clinician personally".	Is the statement about self-disclosure? Yes No If Yes, rate amount of self-disclosure: 1-------2-------3-------4-------5	
"Sometimes self-disclosure is very helpful".	Is the statement about self-disclosure? Yes No If Yes, rate amount of self-disclosure: 1-------2-------3-------4-------5	
"...do disclose some information about myself...if helpful to client".	Is the statement about self-disclosure? Yes No If Yes, rate amount of self-disclosure: 1-------2-------3-------4-------5	
"...don't mind certain disclosure; for example, similar experiences...might share a little".	Is the statement about self-disclosure? Yes No If Yes, rate amount of self-disclosure: 1-------2-------3-------4-------5	

1----------2----------3----------4----------5

not self-disclosing at all	low self-disclosing	moderate self-disclosing	above moderate self-disclosing	high self-disclosing

Singapore Practitioner's Comments	**Rating Self-disclosure**	**Your Comments (themes, if any)**
"Minimal".	Is the statement about self-disclosure? Yes No If Yes, rate amount of self-disclosure: 1-------2-------3-------4-------5	
"...keep to minimum what is necessary in therapy".	Is the statement about self-disclosure? Yes No If Yes, rate amount of self-disclosure: 1-------2-------3-------4-------5	
"...allow if it is going to help, some of it".	Is the statement about self-disclosure? Yes No If Yes, rate amount of self-disclosure: 1-------2-------3-------4-------5	
"We draw boundaries. Minimal disclosure, ...always towards end of therapy".	Is the statement about self-disclosure? Yes No If Yes, rate amount of self-disclosure: 1-------2-------3-------4-------5	

APPENDIX I

Frequency of Western Therapy Models in Use by New Zealand and Singapore Mental Health Practitioners

	Mostly		More than Half		50/50		Less than Half		Not at All		Indicated without frequency		Undisclosed	
	NZ	SG	NZ	SG	NZ	SG	NZ	SG	NZ	SG	NZ	SG	NZ	SG
Alderian model	-	1	-	1	-	2	4	7	22	25	-	-	27	37
Behavioural model	6	8	14	14	12	21	5	3	-	3	-	1	16	23
Cognitive model	21	10	15	17	6	18	2	4	-	3	5	5	4	16
Eclectic/Integrative model	13	18	6	12	8	5	3	2	3	10	-	1	20	25
Existential model	2	1	3	6	9	10	8	7	10	16	-	-	21	33
Experiential model	2	1	2	7	8	11	8	6	9	16	-	-	24	32
Gestalt model	1	-	2	2	6	6	11	12	10	17	-	-	23	36
Humanistic model	3	4	2	8	13	10	8	6	5	13	-	-	22	32
Interpersonal model	3	4	6	12	14	11	6	2	1	8	-	-	23	36
Psychoanalytic/ Psychodynamic model	6	-	6	7	6	10	12	6	7	15	-	2	16	33
Rogerian model	2	5	7	11	11	11	5	3	6	8	2	2	20	33

Note: NZ = New Zealand participants (N = 53); SG = Singapore participants (N = 73).

Other Western Therapy Models in Use by New Zealand and Singapore Mental Health Practitioners

New Zealand participants		Singapore participants	
12-step Facilitation	1	Behaviour Management	1
Attachment Therapy/Object Relations	1	Bible	1
Buddhism	1	Client-centred Approach	1
Client-centred Approach	1	Jungian Approach	1
Cognitive Behaviour Therapy	10	Post-modernistic Problem-solving Approach	1
Constructive Approach	1	Reality Therapy	2
Counselling	2	SATIR Model	1
Dialectical Behaviour Therapy	1	Solution-focused Behaviour Therapy	5
Emotion-focused Therapy	1	Narrative Therapy	1
Eriksonian	1	Strategic Therapy	1
Eye Movement Desensitisation & Reprocessing	3	Systemic Family Therapy	4
Interactive Art Therapy	1		
Mind-Body Integration	1		
Narrative Therapy	4		
Personal Construct Theory	1		
Process-oriented Psychology	1		
Rogerian Approach	2		
Schema Therapy	1		
Solution-focused Approach	1		
Strategic Approach	2		
Systemic Approach	2		
Transactional Analysis	1		
Trauma-focused Approach	1		

APPENDIX J

Frequency of Therapy Interventions in Use by New Zealand and Singapore Mental Health Practitioners

	None at all		1-10%		11-20%		21-30%		31-40%		41-50%		51-60%	
	NZ	SG	NZ	SG	NZ	SG	NZ	SG	NZ	SG	NZ	SG	NZ	SG
Behavioural Management	-	-	14	14	3	9	5	3	1	1	2	3	1	2
Brief therapy	3	3	7	10	2	7	6	3	1	-	2	-	-	1
Cognitive therapy	1	2	11	9	3	4	4	7	1	-	2	2	2	1
Cognitive-behavioural therapy	-	-	3	13	6	6	5	5	1	2	4	5	4	1
Emotion-focused therapy	3	5	4	8	2	3	-	3	1	1	3	-	2	-
Family therapy	4	3	10	12	2	7	3	6	-	-	2	4	1	3
Marital therapy	1	2	9	14	9	6	4	5	1	1	1	1	-	2
Narrative therapy	5	8	7	11	1	1	1	-	-	-	2	1	-	1
Psycho-education	-	1	11	8	5	7	2	2	2	1	3	2	2	2
Relaxation	-	3	12	15	6	3	3	1	3	2	1	1	2	3
Stress management	-	2	7	16	3	7	3	1	5	3	2	2	2	2
System Therapy	2	4	8	6	-	3	-	1	1	1	3	1	-	1

	61-70%		71-80%		81-90%		91-100%		Indicated without frequency		Undisclosed	
	NZ	SG	NZ	SG	NZ	SG	NZ	SG	NZ	SG	NZ	SG
Behavioural Management	1	2	-	3	-	-	-	1	3	2	23	33
Brief therapy	3	5	2	3	1	1	-	3	1	-	25	37
Cognitive therapy	1	-	4	1	1	2	3	-	1	-	19	45
Cognitive-behavioural therapy	2	2	6	1	2	2	6	1	10	5	4	30
Emotion-focused therapy	2	-	-	4	1	-	1	-	1	-	33	49
Family therapy	-	-	-	3	1	-	-	1	2	1	28	33
Marital therapy	-	-	-	1	-	-	1	1	1	-	26	40
Narrative therapy	1	-	-	-	-	-	-	1	4	-	32	50
Psycho-education	-	-	1	-	-	2	5	-	2	-	20	48
Relaxation	1	1	-	1	-	1	2	-	2	-	21	42
Stress management	-	1	1	-	1	1	2	1	1	-	26	37
System Therapy	-	-	1	5	-	2	-	3	1	2	37	44

Note: NZ = New Zealand participants (N= 53); SG = Singapore participants (N = 73).

Other Therapy Interventions in Use by New Zealand and Singapore Mental Health Practitioners

New Zealand participants		Singapore participants	
Constructive	1	Counselling	1
Counselling	2	Eclectic Approach	1
Couple Therapy	1	ERC	1
Dreamwork/Integrative Art Therapy	1	Jungian	1
Eclectic Approach	1	Pharmacotherapy	2
Eye Movement Desensitisation &		Play & Draw (for children)	1
Reprocessing	2	Play Therapy	1
Eriksonian	1	Psychodynamic Psychotherapy	1
Play Therapy/Sand tray	1	Reality Therapy	3
Psychoanalytic/Psychodynamic	5	Rogerian Approach	2
Psychotherapy		SATIR Model	1
Rogerian Approach	3	Strategic Approach	1
Schema Therapy	1	Systemic Family Therapy	1
Strategic Family Therapy	1	TEACCH / Picture Exchange	
Transactional Analysis	1	Communication	2
Variants of CBT e.g. DBT	2		

APPENDIX K

Statements by New Zealand and Singapore Mental Health Practitioners on Preference for Western Therapy Models

New Zealand Participants	*Singapore Participants*
Empirical evidence/training	
• Believe it is most effective. • CBT/Analytical nature. • CBT-Research shows extremely effective therapy particularly for client population seen here. CBT is the accepted therapy to be used in this service (not …for long-term therapy). • Cognitive therapy, evidenced based. User friendly for clients. • Demonstrated effectiveness (literature-based) outcome evidence. • Developmental concepts; Relationship theory; Psychodynamic. • Effectiveness outlined in the literature. • Efficacy. • Empirical evidence. • Empirical research showing effectiveness of therapy for presenting disorder. • Empirical validation of treatment. • Evidence based CBT, but also use Narrative, NCP, EMDR (which is also evidence based), i.e., primarily, I use evidence based approaches but also those like Narrative, NCP which appear to have effective outcomes. • Evidence based, so I use CBT/IPT. • Evidence-based practice guidelines for specific problems (what works for whom). • On psychological literature. • Research (CBT) Scientist Practitioner Model. • Systemic/Strategic because systemic deals with families, whereas strategic is directive and confrontational; behaviour therapy for children. • Based on training • Training	• Behaviour Management • CBT • Effectiveness/the potential for effectiveness. • Efficiency (what experience or empirical evidence had shown to work). • Informed by systemic orientation. • It is based on fulfilling the necessary requirements of Person Centred Therapy. • Jungian psychotherapy because very much Eastern, rooted in traditional Chinese beliefs. • Solution Focus Therapy, SATIR Model. • Adequate training/Being trained. • Based on past training. • Professional training. • Training I went through. • Training received at University.
Practitioner's personal preference[a]	
• According to my level of skill in addressing those needs. • Clinical expertise. • Depending on client /Eclectic for difficult clients/ • Eclectic but focuses on problem-solving. • Experience. • Flexible due to experience; use different tools/models e.g. EMDR, brief, constructive, cognitive, narrative, Gestalt.	• Comfort level and knowledge of the therapy model. • Counsellor's competency. • Eclectic but have preference for RT, behaviour management, CBT, or dependent on client's issues; preference for solution-focussed, client-focussed concrete results. • Fit with my belief system. • Fits best with my life philosophy, principles, values and personality; makes

• Personal preference. • What I rationale with my training.	sense, is practical and can see results. • I choose it on what I believe is of the most benefit to patients. • I choose the therapy that I believe most strongly in; and one that I am most comfortable with. • Interests. • Personal understanding and ability to apply such skills. Confident too as some therapy may need specific skills. • The paradigm matches my philosophy of life. • The therapy model must make sense to me and I find it useful in my work with clients.
Client's personal preference[b]	
• According to individual's needs • Based on presenting issue. • Client base. • Client issues, personality, goals, needs. • Client needs a match (i.e. cultural factors may indicate choice). • Client presentation. • Client problems. • Needs of the client. • Suitability with clients. • The needs of the client, the gender and culture of the client. • The type of presenting problem.	• Based on the needs of the child. • Client to come to own solution. • Client's comfort/educational level. • Counselling issues presented by client. • Depending/Based on client's/patient's needs. • Depends on what would be most appropriate for the client, and what his needs are. Approach and intervention strategies/ techniques would depend on issues/problems identified. • Helpfulness to presenting and assessed issues of client. • Nature of presenting problem. • Personal receptiveness of clients. • Presenting problem and characteristics of the client/patient. • Suitability of patient. • The capabilities of patient (psychological profile); the significant/presenting problems. • Type of problem patient faces. • Usually based on the presenting problem and patient type.
Organisation's practice	
--	• Agency's mandate.

Other concerns	
• Its potential to reveal the client's constructs. • Results of initial assessment and diagnosis and age/developmental status of individual.	• Assessment of case. • Christian based or non-contradictory. • Compassion for prisoners. • Cost effective. Fits in with Singaporean mindset of fast results. • Practical realities/Practicality. • Spiritual. • The ultimate healing is from God. • Time-Constraints. • Timeframe and resources available.
Combination of above	
• Client/therapy match. • Evidence of literature, delivered in an approach that is tailored to the needs of this individual client. • How it fits with client's needs and resources; how familiar and comfortable I feel with the particular approach. • Match the kind of intervention to the issue and to what will fit best with the person. • Matching client needs to my personal skills. • My own preferences according to my own wisdom and personal learning, b) a range of techniques to suit the personality style and problems of my patients. • Rogerian client-centred therapy; suits practitioner's philosophy and personality. • What appears to fit the client and what is scientifically supported.	• Agency's influence and effectiveness of therapy. • Based on personal preference (e.g. Rogerian approach) and agency's practice (e.g. Systemic practice; family therapy). • Eclectic and CBT/concrete/effective. • Effect of therapy on clients; Enable to empower clients and gives space to workers in looking at things differently, so don't feel stuck. • Flexible/Eclectic/Counselling. • Good scientific evidence it is efficacious and I agree with its rationale. • My own training & experience with that form of therapy. • My training and organisation's culture & practice. • Oriented toward a certain approach is important but it is equally important to put it on hold when another type of therapy may be more useful/helpful for the client. • Realization that human emotions originate from human thinking. • Rogerian because problem-solving, solution-focused, people/client-centred, suitable for individual. • Systemic/Strategic Approach because of working with families; but dependent on client issues. • That it would suit the client's needs [as I perceive it] and not vice-versa.

Note: New Zealand Participants (N = 53); Singapore Participants (N = 73). Repeated statements are deleted for ease of presentation.

[a]Practitioner's personal preference includes beliefs, feelings, experience, expertise, rationale and choice.

[b]Client's personal preference includes needs, goals, problems, personality, gender, culture, and suitability.

APPENDIX L

Statements by New Zealand and Singapore Mental Health Practitioners on Relevance of Western Therapy Models to Population

New Zealand Participants	*Singapore Participants*
Relevant	
• A mix of Eastern and Western style of therapies—i.e. therapy-centred plus client-centred—moderation like CBT working together by therapist and client. • Advanced in terms of knowledge base and dealing with specific disorders. • Because of stressful lifestyle; medication not helping alone; people are thus open to talking about problems, problem-solving. • But getting better. • CBT has 10 years build-up as accepted mode of practice in NZ; and therapies are integrating—CBT, DBT, schema therapy, behaviourism, etc. • Counselling skills apply across all cultures; important for client is good command of English in NZ. • Culturally sensitive services are available in main centres generally. • Depends - if Caucasian probably good. Others not so good - much ignorance and arrogance I think. • Depends on the situation - great variation. • Depends on who, where, what client groups, etc. • For Caucasian culturally appropriate, sometimes not very and for other cultures, however, some aspects useful e.g. CT. • Have strategies for Chinese and Maori; e.g. include family. • I don't have enough Asian therapists for Asian clients if they preferred; but have for Maori and Pacific Islander clients. • I don't really diagnose or even fully recognise "disorders" as facts. I look at the same phenomena from a different perspective, that of relationship and peoples need for people and what has got in the way of that. I believe that generally to achieve a greater overall sense of satisfaction may require 2-6 years of weekly (or more frequent) therapy. This is the area of personality but not necessarily personality disorder. Though some categorising may be useful, I think of each person's personality and difficulties if relating as unique. I don't really apply therapy techniques very much; depth of relating at a level useful to that person is my 'tool'.	• Adapt to various cultures e.g. with low income groups, basic needs come first, so build rapport and trust; foreigners needs (preferred) local jargon to work here. • Better educated, more affluent, has better knowledge of these services, sophisticated, maturity of people, higher participation. • Can be improved. • Clients to have ownership and responsibility. • Clients who seek therapy know that there are a plethora of therapeutic interventions in Singapore to suit their needs (via media), as there are many therapists in Singapore with various expertise/years of training. • Common language in therapy better; work within culture and beliefs of clients. • Depends on counsellor to make it appropriate in presentation. Must be down to earth. • Depends on education, SES, language, age of clients. Western approaches are more 'useable' with highly/English educated, middle/upper class, and younger clients. • Education and exposure to in/out? And knowledge; greater demand. • Focus on relationship, rapport, mutual respect, and transparency. • For others, need to adapt/modify.... • Generally more accepting as tool through Family Service Centres. • Good future, new age of awareness, discovery, understanding; catching up fast. • I believe it is relevant. Unfortunately, there are not many proficient practitioners. • In my experience, I feel strongly that the relationships factors between counsellor and counsellee are of utmost importance in contributing to success in counselling, more so that the counsellor's use of skills and therapeutic approaches. Hence, recently, I've been very much drawn to

- I have had training working with specific ethnic groups (e.g. Indian, Asian) but my judgement re suitability has to relate to the individual firstly with consideration to how they identify with whatever ethnic group.
- I think this will vary depending on the population structure of the area you live in.
- Important for practitioners to have expertise, proven track records, got what clients want regardless.
- Improving, but not for all cultures. Our cultural climate is also changing - training should reflect this.
- It is essential that Clinicians receive training in effective techniques and in appropriate responses to clients of cultures different from their own or that in which their training is based. This means they need to have a good understanding of their professional & cultural boundaries & an awareness of how to operate in those cultures in which there is an expectation they will work. This will not always involve them directly providing services - often they will need to work with & through others more familiar with that client group & its belief-systems, mores & practices.
- Life gets busier, family issues more complex—separation, divorce, repartnering—need external person to go for support, advice to validate experience; because traditional communities are breaking down.
- Lots of similarities between Western models; Rogerian universal.
- Mainly western models (ego-centric) used.
- Many students are open to counselling after "orientation" by school and counsellor.
- Māori Kaupapa Services provide culturally appropriate services. It is difficult to access other ethnic groups.
- Might be better to have own ethnic therapist for clients for better understanding of client's position; otherwise have to take middle-ground.
- Most people don't have difficulty with psychiatrists even though they don't like to see them.
- My approach is adaptable to others cultures, though I remain Pakeha.
- Need for professional therapists, counsellors and ministers.
- DBT has lots of Eastern ideas like mindfulness, meditation.
- Optimistic about having therapy support that works more and more with cultural support system to develop wellness, and unwellness.
- the theory and practice of Narrative therapy and the use of collaborative conversations. These transcend age, educational background, SES, language, culture ... as the need to be listened to; to be understood is an overriding value.
- Language needs to be simplified for clients/patients.
- Local therapists not sharing their knowledge for the better.
- Models are universal; are more interested in clients' needs.
- Most therapy models originated from the west - needs to be adapted to suit needs of clients here.
- Multi-racial & multi-cultural society.
- Need for more regulation to protect clients.
- No problem with ethnicity of Singaporeans.
- Not with gender too, initial adjustment only.
- People are stressed up.
- Practices must be dropped or modified for any working relationship to evolve. E.g. Unwillingness of Asian patients to discuss intimate issues in groups. Etc.
- Practitioners to have tact, be non-judgemental, have empathy regardless of ethnicity of therapists.
- Professionally trained therapist would understand cross-cultural issues. Unfortunately many therapists are products of weekend courses!
- Psychiatrists are more effective because of provision of medication needs for mental illness.
- Psychotherapy is still in its infant stages in Singapore, a society (Asian) which places more value on externals rather than what's really going on inside, I think.
- Singapore is modern for these services.
- Still applicable if we modify some aspects to fit the client.
- Still young, exploring, but works for everyone; some way for professionalism and recognition; needs more public education on them.
- The appropriateness is context-specific, depends on how workers utilise their beliefs in influencing their practice.
- Therapy language is simplified in a way that local clients understand.

• Our community is predominantly Pakeha & this is therefore not an issue. • Practitioner's job is like translator of model less for Caucasian, but have to be beware of their upbringing. • Services give challenge to stigma and discrimination with respect to disorders of the mind. • Some move for public sector already; more funds for employing psychologists and social workers. • Some therapies are more appropriate than others. Narrative seems to be most respectful of clients. • Therapy has something to offer everyone regardless but differentiate psychologists, counsellors, and psychotherapists. • Too broad, some people are cultural appropriate, others not. • Use instincts with clients—learnt from experience what client needs, provide information, let client work on it, guide as necessary. • Use interpreter if client has language problem; initial assessment important, especially acculturation issues; use visits to other therapies—pastor, monks—by clients to see difference; involve family of client, because they see client 7 days a week. • Varies greatly/Varies place to place. • We try to be culturally appropriate to Māori and PI, and aware of other cultures but still have more to learn. • Migrants have different acculturation issues—bond's acculturation model applies well. • Intermarriage problems a matter of communication. • Family sees client 7 days a week; hence, important involve family in therapy generally, especially with Chinese and Maori families. • The trick is to make counselling and psychotherapy understandable, interesting, palatable, and useful for the client.	
Not Relevant or Problematic	
• CBT, DBT, family therapy work for Europeans but struggle with non-Western cultures. E.g. doesn't fit or not effective with Maori culture--Maori family system, complex, extended, who holds power not immediately apparent, might be uncle. NZ not employing counsellors in public sector. • Clients whose English is second language may not understand what is said; helpful to check back with client on what is discussed.	• Knack of stigmatisation.

• Interpreters for clients may not necessary tell everything. • Southern NZ is different from North Island - much less cultural diversity. Don't know. • Counselling is talking; clients may have stigma about it. • Danger of quacks practising them. • Difficult to generalize. • Dispute over roles of counsellors and psychotherapists—who is doing what? • I am concerned there is a growing tendency for professional self-development courses to present a number of therapeutic approaches of a superficial nature, which leads to an "add-on" attitude to therapy, where the more versatility there is for? The repertoires of therapies, the greater the status of the therapist - often on a minimalist training basis (e.g. intensive week-end) and superficial theory and research basis. • Lack evidence of generalisability of models; CBT with White middle-class, seldom 8-15 sessions plus cure; cultural sensitive not available. • Lip service is paid to culturally safe practice. • Not suitable with respect to technology, cultural differences and values—models of the 40s to 60s. • NZ social workers cannot do counselling; just generalists in practice. • Some models are not suited to Chinese clients e.g. free flow talking about spirituality. •	

Note: New Zealand Participants (N = 53); Singapore Participants (N = 73). Repeated statements are deleted for ease of presentation.

APPENDIX M

Statements by New Zealand and Singapore Mental Health Practitioners on Clients' Reasons for Request for same Gender/Ethnic Therapist

New Zealand Participants	*Singapore Participants*
Cultural/Language issues	
• Culture issues. • Ethnicity - belief that therapist will have greater understanding of contextual issues. • Feel someone from their ethnic group would be more empathic, understand their situation better. • Language/pronunciation/dialectal problems. • Prefer same ethnic group.	• Clients feel that understanding of presenting concerns can best be facilitated if therapist shares similar sociocultural background. • Ethnic group - because of the 'language' e.g. Hokkien speaking, Mandarin/Cantonese-speaking clients. • Generally linguistic issues have more bearing on their preferences than ethnic. • Language/communication. • Looking for expatriate therapists - same cultural background. • Malay community may see it more relevant to get help that involve spirituality. • Religious grounds. • When problems are closely related to religious/cultural practices.
Client's personal preference	
• Believe psychologist may be biased against them if not same gender. • Believing they will relate better with a male or need to do so. • Clients who find women easier to talk to. • Difficult to determine - often clients come to me because want woman. • Gender issues. • Gender requests usually a woman requesting female therapist. • Lesbian/gay issues - prefer same sexuality; Maori/Pacific Islanders may prefer their own. • Never request for ethnic preference. Sometimes preference for female therapist. • Occasionally clients want to work with woman practitioner or see a doctor. • Younger girls prefer female counsellors.	• A trend that I observed: Female prefer to speak to female psychiatrists but elderly men prefer men (elderly men can be chauvinistic especially Chinese or Indian men) • Clients believe that therapists of the same gender would be able to understand their problems better. • Client's preference. • Hope to hear views they think would be more balanced. • Patients make their choices when making initial contact. • Very lonely patient admits gender preferences. • Will understand them much better.
Comfort/Safety	
• Increased level of comfort and understanding. • Personal comfort; trust; past trauma (sexual). • Sense of comfort being understood. • Trust/safety issues.	• Client feels that he/she would be more comfortable and would be able to disclose more and less inhibitions. • Client's own comfortability. • Comfort level of clients. They feel understood better by same gendered therapist. • Feel more comfortable with same sex or ethnic groups. • Identification & level of comfort. • Level of comfort for self-disclosure. Initial distrust that therapist might not understand with gender & cultural nuances.

Problem-based	
• Clients often request a female therapist due to abuse issues. • Gender - may have history of sexual abuse or other negative experiences with a particular gender. • Gender/Abuse issues, power issues. • History of sexual abuse. • Post trauma, better identify with one approach or other. • Sexual abuse by male, feel more comfortable with a woman. • Sexual abuse experiences, "Needing appropriate role model". • Sexual abuse predominantly or problems with authority. • Sexuality concerns. • Usually sexual abuse clients who have problem relating to males. • Women who have had negative experiences with male therapist.	• Clients' discomfort in discussing sexual disorder. • Except race cases or rape trauma, etc. • For same gender therapist due to sexual problems. • Ladies wishing to talk of married or sexual issues. • More so marital status: where in marital counselling, client would prefer married counsellor, or for parenting issues, counsellor who has children. • Nature of presenting problem. • Sexuality issues involved. • When it is related to marital, sexual, or abusive issues.
Organisation	
• "We have our own way of doing things"	• Being primarily school-based, I think the students/clients may not realise they have any options here!
Other concerns	
• Males wanting female therapists. • Often also encounter people who do not want same ethnic group mental health worker. • Service offered Asian counsellors; language difficulties. • Some clients don't want own ethnic therapist; e.g. Chinese and Maori.	• Because I am a Permanent Resident, not a Citizen. • Some are Christians, Buddhists, or Muslims-—deal with appropriately. • Some clients e.g. in army hoping for more "lenient" Dr.
Combination of above	
• Age/cultural issues. • I ask! Sexual issues; age/cultural issues. • Males wanting female therapists; Gays wanting gay therapist; same ethnicity therapist e.g. Maori clients wanting Maori therapists. • Service offered Asian counsellors; language difficulties.	• Caucasian clients may first ask for same ethnic therapist, but with Asian therapist, initial hesitation, then understand and open up. • Clients are more comfortable speaking to a therapist of the same gender. Clients also hope therapist's ethnicity and gender would help him/her to understand clients better. • Clients comfort level, nature of presenting problem. • Clients prefer that they will feel more comfortable in talking to the same gender. • Easier to identify with client. Higher comfort level. • Issue of comfortability/sexuality issues involved. • Very few cases that prefer the same gender feeling that the issue (e.g. drug abuse) and person qualify a similar gender.

Note: New Zealand Participants (N = 53); Singapore Participants (N = 73). Repeated statements are deleted for ease of presentation.

APPENDIX N

Statements by New Zealand and Singapore Mental Health Practitioners on Diagnostic Systems

New Zealand Participants	*Singapore Participants*
DSM IV	
• A guide to client's problem. • Because it pathologises, rather interested in client's case/details. • Common language for professionals; saves time and description; ease of referral. • Counsellors or therapists that belong to NZAC (New Zealand Association of Counsellors) professional body, do not generally use formal diagnostic tools such as DSM IV, this is considered 'labelling' of clients and this is seen as detrimental to the therapeutic process, therapists are generally knowledgeable of the DSM IV but use it only with extreme cases. • Explain emotional status of clients. • Framework by which to understand client. • In Auckland give access to services funding. • Labelling; stigma. • Limitation wit children; rather behaviour problems. • Look up research from them. • Prefer to use symptoms to describe clients. • Quite useful as a tool. • Rather give criteria to client to self-assess. • System requires it to be done. • Usually psychiatrists diagnose with DSM; routine use by psychiatrists.	• Diagnosis done before treatment/seen by practitioners i.e. done by psychiatrists or referred cases to psychiatrists to diagnose. • DSM IV is widely used. • Find it labelling. • Preferred assessment/case formulation method/ see client's problem and have conference/analysis. • Use because psychiatrists/doctors use them. As I conduct more counselling/psycho-educational training in my line of work, my assessment-tools are quite often less DSM IV-based.
Assessment Procedures	
• Appropriate to client level/disorder. • Are baseline measures, idea of progress, highlight problem areas; culturally not appropriate; American ones not even suitable to NZers. • Are good adjuncts to clinical interviews. • Clinical useful though are American and Australian. • Gain additional information on clients. • Had Chinese versions of BDI, CDI (tested in Taiwan and HK). • Highlights what's from interviews. • Indicate on report if client had difficult with tests/scales. • Limitation of tools, rather interpret results. • Not therapeutic, rather educate family about health status. • Not to use whole assessment on	• Find it universal and appropriate. • Organisation requires so. • Find them helpful to explain facts, clarify diagnosis. • Find them labelling. • Not required by organisation to do so • Refer to external sources to do them • Scales are easy ones to understand by clients. • Modified them for use. • Rather collect information from client through sessions. • Tools are Western. • Use own checklists.

psychometrics; or confront client with stacks of papers rather for homework. • Pre- and post-test measures for intelligence, intellectual and neuropsychology. • Refer out to clinical psychologists to administer tests/scales. • Send client away with questionnaires to save time. • Use cultural/language appropriate versions of tests/scales for specific clients e.g. Chinese. • Use mainly Western ones (e.g. American, Australian, British). • Whether user-friendly/useful, if not drop them.	
Examples of Usage	
• Use tests with 2 couples--Kiwis and South African--highlights what is known from interviewing. • Ease of referral; mention ADHD in report, judge may give some leniency. • Psych tests may be difficult--use of WAIS with Sri Lankan boy, 19, difficult because of concepts sound foreign, also some of language used; same for Asperger's or autism because of decreased capability of clients.	• --

Note: New Zealand Participants (N = 53); Singapore Participants (N = 73). Repeated statements are deleted for ease of presentation.

Other Diagnostic Systems in Use by New Zealand and Singapore Mental Health Practitioners

New Zealand participants		Singapore participants	
Characteristics Styles-M.Willm	1	Case formulation	1
PAnl/Gest		Systemic Therapy assessment	1
Dynamic formulation method	1	DISCO-DiaItwfSoc&Com	2
Functional Analysis	1	In-house Assessment Tools-RPS	1
		Needs Assessment	1
		Social Work assessment	1

APPENDIX O

Frequency of Assessment Procedures in Use by New Zealand and Singapore Mental Health Practitioners

	Mostly		More than Half		50/50		Less than Half		Not at All		Indicated without frequency		Referred out		Undisclosed	
	NZ	SG	NZ	SG	NZ	SG	NZ	SG	NZ	SG	NZ	SG	NZ	SG	NZ	SG
Draw-a-person diagnostic tool	-	1	-	2	3	6	3	3	33	32	-	-	1	-	13	29
Rorschach	-	-	-	-	-	1	3	-	35	38	-	-	1	-	14	34
Sentence Completion Methods	-	1	-	1	2	9	6	3	31	33	-	-	1	-	13	26
TAT	-	-	1	-	2	1	2	1	33	37	-	1	1	-	14	33
Raven's Progressive Matrices	-	-	2	3	2	4	6	1	24	32	-	-	1	-	18	33
Stanford-Binet IV	1	-	-	1	1	3	3	1	29	32	-	1	1	-	18	35
Wechsler Intelligence Scales	5	4	3	5	12	6	4	3	13	25	2	6	2	-	12	24
Anxiety/Depression Inventories	14	4	6	3	9	12	3	5	8	19	10	1	-	-	3	29
Neuropsychological Tests	2	-	2	3	7	2	5	-	18	31	1	-	1	-	17	37
STAI	2	1	6	-	4	-	2	-	21	35	-	-	1	-	17	37
WMS	3	-	1	2	7	1	3	-	19	34	-	-	1	-	19	36
SCL-90	3	-	3	-	3	-	2	-	23	35	-	-	1	-	18	38
16PF	-	1	-	1	-	1	2	3	28	32	-	-	1	-	22	35
MMPI	-	1	5	3	2	4	3	4	22	29	1	1			20	31
MCMI	-	1	-	-	3	-	7	1	23	32	-	-	1	-	19	39

Note: NZ = New Zealand participants (N= 53); SG = Singapore participants (N = 73).

Frequency of Other Assessment Procedures in Use by New Zealand and Singapore Mental Health Practitioners

New Zealand participants		Singapore participants	
Achenbach Scale	1	Adp Behaviour Scale	1
Anti Depression Test	1	BayleyII/ BayleyScof Infant Dev-2ndEd	2
AUI	1	Connors Behaviour Checklist	1
Behaviour Checklist	1	California Psychological Inventory	1
Connors Behaviour Checklist	11	EQ Mapping	1
Chinese version of BDI & CDI	1	FIRO	1
Dysfunctional Attitude Scale	1	Jung's Anxiety/Depression Scales	1
EAT	1	Kaufman	1
EDI	1	Marital & Stress Scales	1
MAYSI	1	MBTI	3
NEO PI	1	Own Checklist	1
Observation Method/PCP Methods	1	ENRICH	1
PANNS/PsyRATS/HONOSCA	1	PREP-R	2
Parenting Measures	1	Rating scales	1
Personality Inventories	1	SDS/Self D Search	2
Rivermead, Peabody Luvic Screen	1	Strong Stress Inventory	1
RMCA	1	Taylor Johnson Temperament Analysis/	
SAST/MADRAS	1	Inventory	6
Sexual Attitude Questionnaires	1	Test of Memory / Test of Learning	1
STAX-I	1	VABS/Vineland	3
Suicide Checklist	1	WPPSI-R/WRAT-R/BPVS	1
Trauma Checklist /Trauma kit	3	PANS	2
TSCC	2		
Young Schema Questionnaire	3		

APPENDIX P

Clients seen in Practice in 2001

	None at all		1-10%		11-20%		21-30%		31-40%		41-50%		51-60%	
	NZ	SG	NZ	SG	NZ	SG	NZ	SG	NZ	SG	NZ	SG	NZ	SG
Caucasians	1	8	-	18	-	4	-	1	1	-	4	-	1	-
Chinese	2	1	15	2	1	1	1	2	-	2	-	8	-	5
Indians	2	1	10	45	2	7	1	1	-	2	-	1	-	-
Japanese	5	9	4	6	1	-	-	-	-	-	-	-	-	-
Koreans	6	11	2	2	-	-	-	-	-	-	-	-	-	-
Malays	6	3	1	24	-	13	-	6	-	3	-	2	-	1
Maori	-	10	26	1	9	-	1	-	1	-	1	-	-	-
Pacific Islanders	-	9	21	4	2	-	1	-	-	-	-	-	-	-

	61-70%		71-80%		81-90%		91-100%		Indicated without frequency		Undisclosed	
	NZ	SG	NZ	SG	NZ	SG	NZ	SG	NZ	SG	NZ	SG
Caucasians	3	-	9	-	10	-	15	2	9	-	-	40
Chinese	1	7	-	13	1	16	-	12	5	-	27	4
Indians	-	-	-	-	-	-	-	-	2	-	36	16
Japanese	-	-	-	-	-	-	-	-	3	-	40	58
Koreans	-	-	-	-	-	-	-	-	5	-	40	60
Malays	-	-	-	-	-	1	-	1	1	-	45	19
Maori	-	-	-	-	-	-	-	-	4	-	11	62
Pacific Islanders	-	-	1	-	-	-	-	-	5	-	23	60

Note: NZ = New Zealand participants (N= 53); SG = Singapore participants (N = 73).

Other Clients seen in Practice in 2001 by New Zealand and Singapore Mental Health Practitioners

New Zealand participants		Singapore participants	
Afghanistani	1	Bangladeshi	1
African	1	Eurasian	1
Filipino	1	Indonesian	1
Iraqi	1	Thai	1
Middle-Easterners	1		
Nigeria	1		
Somalian	1		
Sri Lankan	1		

APPENDIX Q

Presenting Problems of Clients seen in Practice in 2001

	None at all		1-10%		11-20%		21-30%		31-40%		41-50%	
	NZ	SG	NZ	SG	NZ	SG	NZ	SG	NZ	SG	NZ	SG
Alcohol Abuse	3	4	14	20	2	-	1	1	1	-	2	1
Anxiety	-	1	9	16	4	6	4	3	3	-	4	6
Attention Deficit Disorder	4	8	13	16	1	2	1	2	-	1	-	-
Autism	7	11	7	11	1	-	-	-	-	-	-	1
Behavioural	3	2	12	10	2	8	1	9	2	4	1	1
Bipolar Disorder	3	8	18	6	1	5	-	-	-	-	-	-
Dementia	11	9	4	4	-	1	-	1	-	-	-	-
Eating Disorder	2	5	16	14	3	-	3	-	-	-	-	-
General Anxiety Disorder	2	5	10	13	1	5	1	-	2	2	3	-
Major Depression	-	4	2	18	9	3	9	6	2	2	2	1
Marital	1	2	12	15	4	6	4	7	3	1	2	3
Obsessive-compulsive Disorder	3	4	17	16	3	1	-	-	1	1	-	-
Panic Disorder	3	6	17	9	3	3	-	-	-	1	1	-
Personality	1	4	6	20	8	1	6	3	2	1	4	-
Phobia	6	5	8	9	1	3	1	-	1	-	-	1
Schizophrenia	6	7	8	12	1	1	1	1	1	-	-	-
Sexual Disorder	5	7	12	12	-	-	2	-	-	-	2	1
Substance Abuse	3	5	10	15	2	1	3	1	2	-	1	-

	51-60%		61-70%		71-80%		81-90%		91-100%		Undisclosed		Indicated without frequency	
	NZ	SG	NZ	SG	NZ	SG	NZ	SG	NZ	SG	NZ	SG	NZ	SG
Alcohol Abuse	-	1	-	1	-	-	-	-	-	-	30	45	-	-
Anxiety	2	2	3	-	2	1	1	-	1	-	10	34	10	4
Attention Deficit Disorder	-	-	-	-	-	-	-	-	-	-	32	42	2	2
Autism	-	-	-	-	-	-	-	-	-	-	34	49	4	1
Behavioural	-	1	-	3	-	2	-	3	1	2	28	22	3	6
Bipolar Disorder	-	-	-	-	-	-	-	1	-	-	31	52	-	1
Dementia	-	1	-	-	-	-	-	-	-	-	38	57	-	-
Eating Disorder	-	-	-	-	-	-	-	-	-	-	27	52	2	2
General Anxiety Disorder	1	1	2	-	-	-	-	1	1	-	29	45	1	1
Major Depression	3	1	2	-	-	-	3	1	-	-	11	30	10	7
Marital	1	2	-	1	1	2	-	1	-	-	21	31	4	2
Obsessive-compulsive Disorder	-	-	-	-	-	-	-	-	-	-	28	50	1	1
Panic Disorder	1	-	1	-	-	-	-	-	-	-	25	53	2	1
Personality	-	-	-	-	1	1	-	-	-	-	23	43	2	-
Phobia	-	-	-	-	-	-	-	-	1	-	35	53	-	2
Schizophrenia	-	-	-	1	-	2	-	-	1	-	35	47	-	2
Sexual Disorder	-	-	-	-	-	-	-	-	-	-	32	52	-	1
Substance Abuse	-	-	-	-	-	-	-	-	-	2	32	48	-	1

Note: NZ = New Zealand participants (N= 53); SG = Singapore participants (N = 73).

Other Presenting Problems of Clients seen in Practice in 2001

New Zealand Participants		Singapore Participants	
Adjustment Disorder	1	Adjustment Disorder	1
Assessments for Courts	2	Conduct Disorder	1
Body Dysmorphic Disorder	1	Domestic violence	2
Child Abuse	1	Down Syndrome / Cerebral Palsy	1
Cognitive Impairment	1	Family-related Problems	1
Conduct Disorder	1	Financial Difficulty	4
Domestic Violence	1	Intellectual / Multiple Handicaps	1
Early Psychosis Syndrome	1	Interpersonal Relationships	3
Gambling Disorder	1	Juvenile Delinquency	1
Head injury	1	Marital, Family & Relational Issues	2
Intellectual Disability	1	Parenting issues / problems Relationships	5
Learning Disability	1	Problems	6
Emergent psychosis	1	School Refusal	1
Mood Disorders	2	Stress	1
Neuropsychological problems	2	Violence	1
Pain Management	1		
Post-natal Depression	1		
Psychosis	5		
PTSD	8		
Relationships	2		
School Refusal	1		
Self-esteem Issues	1		
Sexual Abuse	12		
Stress	2		
Study Problems	1		
Suicide/Self harm	3		
Trauma	1		
Violent offending	1		

APPENDIX R

Statements by New Zealand and Singapore Mental Health Practitioners on handling Self-disclosure

New Zealand Participants	*Singapore Participants*
Accepting some self-disclosure[a]	
• A bit, limited, to put client at ease. • Am happy to make self-disclosure to an appropriate level if beneficial to the therapeutic process. • An important part of relationship, if beneficial self-disclose a bit; client usually ask after 2 years in therapy. • Because dealing with young people, push boundary a bit; prepared to share a bit, because innermost stuff of theirs. • Being asked dependent on stage of therapy or help; probably an age thing--people are very respectful, very grateful to be seen by a doctor • Depending on the ethnicity of the client-will disclose more or less depending on this. • Depends - careful not to do unless will clearly benefit client. But are minority issues here as well. • Depends on clients' issues/profile and stage of therapy. • Depends on why self-disclosure is required. OK sometimes others not. Explanation of decision queer. • Disclose to certain degree, some sharing, because significant or useful to them. • I am careful about when I self-disclose - must be of benefit to client. • I am reasonably open but very appropriate - according to the situation. • I avoid giving advice from personal experience, but do sometimes make comments on my own learning • I self disclose when I feel the client would benefit. • If it is likely to be helpful/useful to the client. • Limit self-disclosure to what is relevant to the client/counsellor relationship. • Limited - only if relevant to clients needs and their % minimal. • Not with mainstream clients; but with Chinese clients because important to do some self-disclosure to build rapport faster, has therapeutic effect too. • Occasional anecdotes if relevant to client issues. • On very limited occasions, self-disclosure is used to illustrate a point related to psycho-education. As a general rule, self-disclosure is not a part of therapy, but when a small disclosure may provide some improvement in connection, e.g. 'Yes, I do have children or I am married', then self-disclosure is made. • Only as last resort and it if indicated by therapeutic opportunity. • Only if helpful to the client. Professional details and background always disclosed.	• According to the situation and only appropriately. • As and when appropriate if I feel that such disclosure will have therapeutic value for the clients. • As and when necessary during the therapy process or when clients ask. • Ask when familiar/At the end of therapy. • Can be done but with limits and on certain patients who do not have problems with boundaries and limit setting. • Certain amount of self-disclosure is at times useful for the therapeutic relationship to work well. • Don't always use this. Use this at a general level rather than personal details. Importance is how much it would benefit clients & not therapist. • Find out how helpful it will be from client's perspective. • I do not mind disclosing about myself as long as I believe by doing so will help the client to change or handle his/her problems better. • I use limited self-disclosure, very limited. • I use self-disclosure when it helps client to accept their difficulties or to understand their problems • I will reveal facts if necessary/appropriate. • If helpful/ adequate to do so • If it is helpful for client, e.g. to normalise his/her experiences. As well as depending on what and when to disclose, this therapist will have a boundary. • If this is necessary, it's put across as 3rd person. • I'll use it only when appropriate -- when it provides insights into clients' thoughts, feelings and experiences. • Minimal self-disclosure. Only do it in situation that would benefit the client (enhance therapeutic relationship) of when client asked specific questions. • No problem. Self-disclosure is made to relate/empathise with clients' current or future concerns. • Not a problem when appropriate. Use it enough times. • Only to be used judiciously if it would help therapy. • Only when the information is useful/helpful for the clients & myself.

• Quite frequently; tell enough to be polite, build rapport as well. • Rarely, only if of therapeutic benefit. • Self-disclosure if useful, use own examples to explain point or gain rapport, because client share personal information; break rules with teenagers, make it comfortable for person. • Self-disclosure is considered as essential component of Gestalt therapy and Process Oriented Psychology. • Self-disclosure to join with people, normalise difficulties of theirs. • Therapist self-disclosure seen as appropriate at times. • To improve rapport but direct it back to client's situation. • Use in small doses when appropriate, with certain clients to illustrate a pertinent point. • Use it where appropriate. • When judged to be appropriate to foster rapport. • When necessary – e.g. at opening of sessions with Maori clients.	• Self-disclosure is only done if it's deemed to be useful reference for clients. Not commonly practised. • Share if appropriate/a little. • Sharing of personal info is dependent on: appropriateness to context of client's situation and asking what client has gleaned from such sharing. • Tend to do it indirectly, rather than disclosing it as a 1st person. But with teenagers, do tend to share more personal experiences. • Try to limit them unless it helps motivate client. • Very carefully! Tend to play it down/lump it together with a more generic "others/people think/feel…etc". But may be 5% of the time I will self-disclose • When appropriate, especially to normalize certain emotions or thoughts. • When client asks/after knowing therapist personally (for a while). • When issue/question arises is stated directly. • When needed, may share some life stories with students. • When therapy is established genuine self-disclosure is very useful for goal achievement.
Not agreeable	
• Avoid it and take it to my supervisor. • Make clear professional boundaries. • Professional information. • With strict confidentially, except for exceptions indicated in the Psych Code of Ethics. • Stick to interpretation of therapy; client preferred practitioner to speak from academic or practical knowledge; would ask client the relevance of personal question.	• Limited to professional information. • Refrain from this. • Set clear boundaries & do not like to self-disclose. • Strictly confidential.
Other concerns	
• Receptive - reflective, E.M.D.R probe.	• Seldom used.

Note: New Zealand Participants (N = 53); Singapore Participants (N = 73). Repeated statements are deleted for ease of presentation.

[a]Accepting some self-disclosure includes minimal disclosure as appropriate for building rapport with the client, sharing professional information, similar experiences, personal experiences or about religious affiliation.

APPENDIX S

Statements by New Zealand and Singapore Mental Health Practitioners on handling Religious or Spiritual Issues

New Zealand Participants	*Singapore Participants*
Discuss religious or spiritual issues and refer on	
• "Spiritual" is fine - I definitely include. I make clear that I am not a "religious" teacher or expert. • Able to discuss spiritual religious existential issues if requested. • Acceptable - good for client to involve their supports and faith. • Am comfortable with this. • Am happy to involve religious issues in therapy if the client finds it helpful. • Another dimension; another tool to assist problem solving. • Clarify what I can do and what I can't. Respect observances such as prayer and sometimes contribute prayer. • Complement therapy; conjunction to therapy. • Deal with it if a sub-goal. • Depends on how much importance clients attach to it. • Even if religion is different from practitioner's, practitioner still wants to understand client's problem, symptoms; what strength drawn from the religion. • Explore attitudes of shame and guilt. • Fundamental meaning of life for person—purpose of life; for some an organised religion. • Handled as part of their belief system/world view. • Happy to discuss anytime. • Helpful for some. • I allow them to discuss such issues but we do not have to dwell on that if not necessary. • I am very comfortable and actually invite it. • I respect client's religions. • If clients have spiritual resources then I use them. But I do not initiate religious discussion. • Incorporate them willingly. • It is their right to do that. I work with how that is for them. • Its' within family; a process; part of family. • May incorporate if client is of same religion as therapist. • No difference to other issues - value spiritual	• Accommodate it, welcome it, process it with them. • Address it if relevant to presenting issue or important to clients. • Allow them to talk about their beliefs as they can be utilised in sessions. • Approached it as a "not knowing' counsellor that seeks understanding through clarification and client's own interpretation of their beliefs. • As it is presented and to the extent they are comfortable to discuss them. • As long as it is helpful to the clients. • Assume a neutral position or adopt a seek to understand his worldview to clients who are either having similar or different religious affiliation. • Be open to their questions. Address myself as free thinker. • Catholic clients ask denomination of therapist; discuss for better understanding/rapport if therapist is of same denomination. • Client draws strength from it; own time with traditional healer. • Complements therapy. • Direct them to trust and commit their lives to Christ. • Go with comfort level of client; it's client's responsibility. • Has place; is helpful. • I am open/Open to talk/Will be open to talk to them. • I welcome such issues in part of its usefulness to client as coping-resource and what client learns about self in the discussion of such issues. • I will listen to their views & not impose mine. • I would discuss religious issues if client wants to do so. • If it relevant for the client, then it may be helpful to involve religious issues. Generally, such clients seem to want to connect with counsellors are comfortable with spirituality and religious issues. • If religious issues is a resource that is helpful

work. • Not a problem/Accepting. • Often talk about spirituality, rather than casual religion, as part of pathway to recovery. • Respect religion of client; spirituality is an important aspect of one's life. • Respect their beliefs and be overt about mine, willing to work in their world. • Talk about it if client brings up; adapt; encourage. • There is role; don't separate from person. • This seldom arises as a problem as religion is approached as any other beliefs/attitudes. Religious practice is not seen as appropriate in therapy although clients are invited to start a first session with a karakia (prayer) if they wish. • Try and accommodate and use. If religious beliefs are contributing to depression/anxiety, may challenge and offer alternatives. • Try and incorporate this as an aid to recovery. • Understand how they fit with person; part of person. • Use it with client if Christian, same as therapist. • With client direction/consultation/respect. • Work in with their framework. Be flexible. • Would explore with clients. • Would have (in) session with family to pray before and after session. • I explore those issues in therapy. If necessary, suggest my client make contact with an appropriate religious leader/guide in the community. • If I cannot accommodate those needs or wishes, I will refer on. • Listen, encourage them to consult with religious figures, refrain from providing personal opinions. • Might refer out to minister, pastor, hospital chaplain, monks, religious leaders, etc.; but do therapy at the same time. • Prepared to discuss. But would advise the client to seek additional spiritual guidance. • Sometimes with difficulty - may try to refer to Christian Counsellor/therapist. • With respect. May need appropriate supervision. May need to refer on.	for clients, • If same religion, use Bible. If does not contradict Christianity. • If they share same religious beliefs, principles from the Bible will be applied. Have not encountered clients of different religions bringing up this issue. • If they wish to I am prepared to discuss such issues with them. Not a problem. • If we are of the same religious faith and if client is agreeable to talk about them, it will be fine. If there are of different faith, I think, it would? be appropriate for me to make any comment. • I'll go along with it. • I'll use it if I have the knowledge. • I'll use it when it holds meaning for clients, and when it can be harnessed as a source of strength and support. • Leading it from religious to spiritual form. • Listen - no judgement. Allow them to make a choice e.g. someone who wants to use a Chinese medicine. • Not a problem. Would work at the level of his faith and his comfort zone. • Personal to individual; Advised to get strength from it - in moderate ie move away from charismatic. • Religion is one approach to solving problems. • Respect client's religious beliefs and learn from them. • Share view with client. • Spirituality is important; man incomplete without it; is beyond therapy. • Talk about it. • Try to understand how the religious issues can be therapeutic for clients and to involve such issues if it is useful for client. • Will discuss with them about their religious inclinations and the role it plays in their lives. May even use it as leverage in motivation. • With respect to the client's preference. • Would allow them to talk about it & evaluate usefulness of this to the clients. • Would encourage if religion is established one, but take medication. • Would use it if client has background, to enhance confidence/calmness. • Refer clients to a church pastor. Network closely with church pastor in the intervention process.

	• Refer to appropriate counsellor. • Usually I would tell them frankly that I am not able to help them in this aspect if I really have no idea how to help, and may suggest they go to someone who is more well versed in religious issues.
Not agreeable	
--	• Beliefs obstruct discussion; though it is part of culture, and neutral to therapy. • Listen but not comfortable. • Try not to get overly involved. • Try not to involve religion.
Other concerns	
• This is too complex to answer briefly and meaningfully. • Advise them it's not an area I work in. • Intervene if religious person stops client taking medication. •	• It hasn't presented itself much so far. • So far, haven't encountered. • Have not met clients who want to do so. • Muslim patients generally ask the therapist early in therapy if I am a Muslim. They prefer to not discuss religious issues. • Other issues are discussed with the focus on "adaptation". Such issues seriously affect marital work in Muslim patients in an adverse manner. • Infrequent.

Note: New Zealand Participants (N = 53); Singapore Participants (N = 73). Repeated statements are deleted for ease of presentation.

APPENDIX T

Statements by New Zealand and Singapore Mental Health Practitioners on handling Traditional Healers

New Zealand Participants	*Singapore Participants*
Acceptance of services	
• Accept whatever spirituality, open mind. • As long as we were able to plan and negotiate to work in a way that is not inconsistent. • At client's request. • But I would want to evaluate the appropriateness in each case. • Client may them more often than once/week therapy e.g. pastor, monks. • Client to make decision; but can discuss about it. • Depends on case and tradition. I select and to which client is agreeable. Traditional healer - too broad a definition; alongside - do you mean in the room in a session? No. • Discuss/analyse traditional healers' issues with client; may refer out for Maori clients or consult Maori expert. • For allowing traditional healer to work alongside, I would want to keep informed. If appropriate. • Go there if wanted; client's own time; will acknowledge that. • Have done that with pastors/ministers; pleasant, helpful to the individual. • I have done this on several occasions. • I would endeavour to make sure we can work in tandem and do not give opposing information or skills. • If appropriate and in my opinion benign. • If the client wanted this, I would work with that. • Important to client; but keep separate. • It is noteworthy for me to know what happens between T.H. and client • May discuss first in group with client and traditional healer; no one talks above client. • Respect them; work with family; family's choice. • They can see them separately and consult/liaise with me. • Traditional healer work with client - No, but in a case-by-case basis. Work alongside - Possibility. • Work collaboratively for client's sake. • Would be part of treatment planning and	• As a tool. • As long as no contraindication/interference • Client came in with priest, prayed with family, (Muslim). • Client is free to use this method to help himself if he finds it useful. • Client to be responsible for it • Cultural aspect; personal to client • Depends on what I am asked to do. May not fully follow. • Different working styles. Usually I accede to family's request to involve a traditional healer to on to have a rapport with the family. • Going to a traditional healer is a choice made by client, I'd respect that. • Have doubts, comfortable, would refer out; but open if done outside. • I encourage them to seek alternative treatment but only before or after psychotherapy, but not during treatment as it. • I welcome other forms of intervention that client deems appropriate and useful for his/her progress. • I'm eclectic. • Must be clear that other roles do not conflict. It depends who the traditional healer is. • No objection based on respect of client's cultural/belief/ value system. • So long as it benefits the client. • Spiritual dimension • The well being of the client is given top-priority. • Would analyse views of traditional healer with client; may have case conference • Would not object to work alongside but this has not happened so far.

agreed by client, caregiver & traditional healer. • Would encourage (traditional healer working with client). • Would need to establish boundaries of confidentiality and how to work together. • Yes- if Maori or other ethnic; No- if Pakeha.	
Objection to services	
• Have some hesitation; though some may help; beware of psychosomatic problems.	• Client consult his/her traditional healer outside our counselling session. • However, therapist finds it will be difficult to work with someone who shares different beliefs of health. • I would not object but I would not encourage clients to seek traditional healing. • Object TH if simultaneously used. Overall comments: I encourage them to seek alternative treatment but only before or after psychotherapy, but not during treatment as it: 1. Tends to change motivational aspects, e.g. Accepting failure prematurely. 2. Difficulty in stating goals of treatment in terms which can be managed by "modern" treatment. 3. Reconciling conflicting models in the client's mind etc. • The therapeutic goals/approaches may be different of even conflict with each other. • Yes (to object to TH) because I don't know what it's all about, at this point in time.
Other concerns	
• I would want to be educated about the practices, aims and outcomes. • My organization would most probably not support this. • Never been asked.	• Be careful of their use. • Client thinks through goals. • Continue to take medication. • I am not familiar with this approach. • Improves patient's compliance. • Never had one. • Not professional to have it in session. • Organization does not have such a system in place.

Note: New Zealand Participants (N = 53); Singapore Participants (N = 73). Repeated statements are deleted for ease of presentation.

APPENDIX U

List of Papers/Presentations

1. Paper titled, "Practitioner characteristics with comparison of counselling and psychotherapy practices between New Zealand and Singapore mental health practitioners" was presented and published in the proceedings of The Inaugural International Asian Health Conference, at the University of Auckland, 4-5 November 2004.

2. Workshop cum paper titled, "A modified cognitive behavioural therapy model for working with Chinese people" was also presented and published in the above Conference.

3. Abstract on paper titled, "Integrating homework assignments based on culture: Working with Chinese patients" was accepted in April 2006 for publication in the *Cognitive and Behavioral Practice*.

4. Paper titled, "Cultural considerations in using cognitive behaviour therapy with Chinese people: A case study of an elderly Chinese woman with generalised anxiety disorder", was published in November 2006 in the *New Zealand Journal of Counselling,* Volume 35(3), 153-162, and presented at the 29th National Conference of the Australian Association for Cognitive Behaviour Therapy, 18-20 October 2006, under the title "Cultural considerations for Chinese people: Implications for CBT".

5. Abstract on paper titled, "Cognitive behaviour therapy in New Zealand and Singapore: From a doctoral study and personal experience" was presented and published (in a book of abstracts) at the 1st Asian Cognitive Behaviour Therapy (CBT) Conference: Evidence-based Assessment, Theory and Treatment, at The Chinese University of Hong Kong, 28-30 May 2006.

6. Paper titled, "Counselling/Psychotherapy with Chinese Singaporean clients" was published in 2006 in the *Asian Journal of Counselling,* Volume 13(2), 271-293.