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Some Considerations Regarding the Present State of Psychotherapy in Japan

—Psychotherapists' Attributes and the Actual Conditions of Treatment and Techniques—

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Abstract : The social need for developing new psychotherapeutic approaches continues to increase. In order to gain an understanding of the present status of psychotherapy in Japan, we conducted a survey using a questionnaire. The subjects were psychiatrists and clinical psychologists engaged in psychotherapy for neuroses and psychosomatic diseases.

In this first report, we present and discuss several findings concerning the therapists demographic attributes and their behavior and attitudes regarding in actual treatment, obtained through this survey and we also make a quantitative analysis of the survey results.

While psychoanalytic psychotherapists tend to frequently adopt a psychodynamic framework, behavioral therapists are less likely to do so. Behavioral therapists more actively plan their therapy regimen than other psychotherapists.

Key words : Psychotherapy in Japan, Therapeutic technique, Neurosis, Psychosomatic disease

Introduction

Nowadays, the application of psychotherapy tends to vart widely, covering area form the conventional functions of alleviating neurotic disorders and psychotic disorders to the newer fields of specialized care for terminal cancer patients, preventing a relapse of coronary heart disease and other psychosomatic diseases, stress prevention, self–actualization ; and many others. The social need for developing new psychotherapeutic approaches has also been increasing. However, in Japan there is little empirical research on psychotherapy regarding such aspects as its efficacy and limits, or comparisons of therapeutic techniques. Both research and surveys on psychotherapy have long been considered to be difficult for the following two reasons.[1)]

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First, therapists cannot be accurately categorized based on such data as their age, sex, years of experience, and self-reported information about their therapeutic techniques, orientation of therapeutic theory, and training. Secondly, for comparisons of therapeutic activities between therapists, or for studies of differences and similarities between therapist groups, it is not possible to have more than one therapist simultaneously interview the same patient or to select patients of a perfectly identical type to compare.

In order to gain an understanding of the present status of psychotherapy in Japan, we conducted a survey using a questionnaire. The subjects were psychiatrists and clinical psychologists engaged in psychotherapy for neuroses and psychosomatic diseases. In this first report, we present and discuss several findings concerning the therapist's demographic attributes and their behavior and attitudes in actual treatment, obtained through a survey and quantitative analysis of our survey results.

Subjects and Methods

The survey subjects were sampled using a stratified method. We initially divided the subject population into two strata of psychiatrists and clinical psychologists. Next, for the sampling base of clinical psychologists we selected the Society of Clinical Psychologists of Japan, which is the largest society of clinical psychologists in Japan, and the Japanese Society of Behavioral Therapy which has many clinicians who do not belong to the former society. For physicians engaged in psychotherapy, we selected the Japanese Society of Psychiatry and Neurology, the largest society of psychiatrists, as the sampling base. Because the study focused on psychotherapy for neuroses and psychosomatic diseases, the physicians selected for the survey all worked in psychiatric departments of university or national hospitals, which were assumed to treat larger numbers of neurotic and psychosomatic patients than private mental hospitals. From these three groups 125, 125 and 250 subjects, totaling 500, were randomly sampled. We believe that the above explained sampling procedure allowed us an unbiased sampling of psychotherapists.

The questionnaire had 65 items relevant to psychotherapy for neurosis and psychoso matic diseases, question's about the individual's attributes and backgrounds including years of experience, concerning basic data regarding their practice such as the number of patients and the average frequency of interview sessions, questions' about the techniques they use, and questions' regarding the actual contents of psychotherapy. In preparing the questionnaire, reference was made to Strupp's [2] questionnaire for attributes and the number of patients, and the Therapist Orientation Questionnaire (TOQ),[3] Fey's Questionnaire,[4] and the Usual Therapeutic Practice Scale (UTP)[5] for contents evalvations of the actual practice of psychotherapy. There were 45 questions concerning the actual contents of psychotherapy, each answerable on a 5-point scale ranging from "never do so (1)" to "always do so (5)."

The survey was conducted during the period from December 1990 to February 1991.

The data of Hiroko Sugiwaka's report were re-examined using the new analysis method in this study.[6] The questionnaire was mailed to the subjects with a request to return it after filling in their responses. The response rate was 43.6%. The responses actually used for analysis were drawn from 128 psychiatrists, 85 clinical psychologists and 5 with no entry about their professional license, thus totaling 218. For the individual analysis, the number of subjects differs between the items because we omitted the responses of missing entries among these 218 responders.

For the data processing, we conducted a one-way factorial analysis of variance. A multiple comparison test (Tukey method) was used as a sub-test for the analysis of variance. A Hitachi HITAC computer was used with SAS (statistical analysis system) Ver.5 to analyze the data.

Results

1. Attributes of the survey subjects

The gender, license, years of experience as

a psychotherapist, and other background data of the subjects are summarized in Table 1. Although not cited in Table 1, the psychiatrists were mostly male (107 out of 128), while the clinical psychologists consisted of an equal number of males and females. Regarding experience as psychotherapists, those with 6 to 10 years of experience make up the largest group with 70 (32.1%), followed by 53 middle standing therapists with a medium amount of experience (24.3%) having 11 to 15 years of experience. Regarding the place of work, roughly half work in hospitals. Universities and colleges include the health management center and counseling facilities on campus. Only a few (6 subjects, or 2.8%) practice at their own psychological counseling offices. The responses for the training institutions include multiple entries.

Table 1. Atributes of survey subjects (n=218)

Sex	Male	151
	Female	59
	No entry	8
Age	～29	24
	30～39	103
	40～49	59
	50～59	21
	60～69	7
	No entry	4
License		
	Physician	128
	Clinical psychologist	85
	No entry	5
Experience		
	less than one year	4
	1～5 years	32
	6～10 years	70
	11～15 years	53
	16～20 years	30
	21or more years	23
	No entry	6
Place of work		
	Clinic	10
	Hospital (～100 beds)	6
	Hospital (～300 beds)	23
	Hospital (301 beds～)	72
	Psychological counseling office	6
	Child welfare institution	9
	Educational institution	3
	University/college	74
	Others	13
	No entry	2
Training institution		
	University/College	149
	Specialized hospital	15
	Self-trained	43
	Overseas	5
	Others	35
	No entry	4

An analysis of the licenses showed that while most psychiatrists were trained in universities or colleges, only half of the clinical psychologists received such training, and a third had trained themselves.

2. Number of neurosis and psychosomatic disease patients

The neurosis and psychosomatic disease patients treated per week are shown in Figure 1. For psychosomatic disease patients, the most frequent responses were 1 to 3 patients a week, followed by 4 to 6 patients a week. Those who do not treat psychosomatic patients at present numbered 83 (40.7%). The most frequent responses regarding the number of neurosis patients were 10 to 12 patients a week including both inpatients and outpatients, with 44 (21.6%).

For the average frequency of interview sessions per patient, which is not indicated in the figure, the most common frequency of session for Japanese psychotherapy is once a week, accounting for 127 subjects (58.7%).

This is because, in most cases, therapy must be provided within the limits of the Japanese medical insurance guidelines. In the second largest group, 73 (33.5%), therapists provided sessions once every two weeks.

These two response groups made up 92.2%, which clearly indicates that most therapists interview theirs' patients once every week or two.

3. Therapeutic techniques

1) Number of techniques used

We investigated how many techniques the therapists used in therapy. The most frequent answer, given by 33 therapists (15.1%), was 4 techniques, followed by 5 techniques for 29 therapists (13.3%), and 3 techniques for 27 (12.4%). Only 4 therapists (1.8%) employed just one technique. The maximum number of techniques employed was 17, as observed in 3 therapists. On

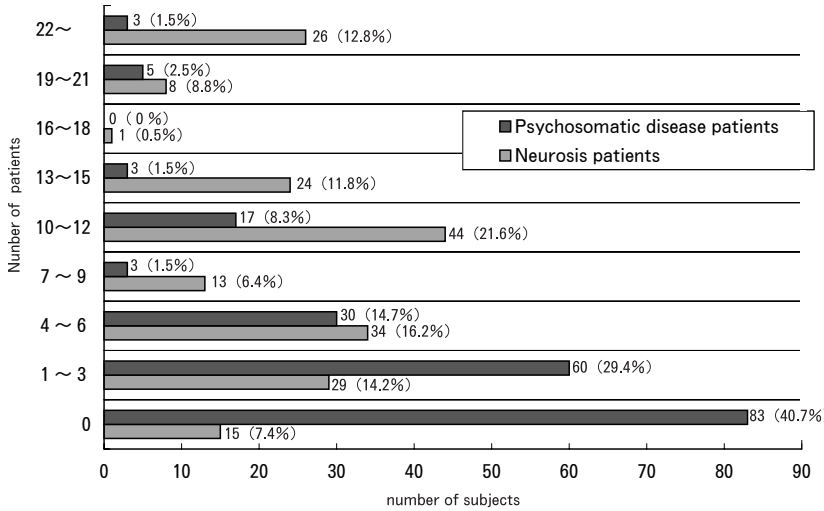

Fig. 1. Number of neurosis and psychosomatic disease patients treated in a week (n=204)

average, the therapists used 6 varieties (6.0 ±3.5) of therapeutic techniques, thus indicating that most therapists have multiple techniques to choose from in accordance with each case.

2) Main techniques

The main techniques the therapists use and whatever sub-techniques they have used are illustrated in Figure 2. Eclectic psychotherapy ranked first as the main technique, accounting for a third of all responses (35.3%). Psyshoanalytic psychotherapy ranked second (15.6%), which uses an almost identical technique as that do psychoanalysis. However, as opposed to the 5 interview sessions conducted per week for the latter, psychoanalytic psychotherapy provides interviews once or twice a week, face to face without using a couch. The subsequently ranked therapies were client-centered therapy (10.1%), behavioral therapy (6.4%), play therapy (3.2%), and Morita's therapy (2.8%). These six therapies constituted 73.5%, or roughly three quarters of all responses for this question.

3) Sub-techniques

Regarding sub-techniques the subjects were asked to enter all techniques they had ever used. Eclectic psychotherapy, ranked top as the main technique, is also frequently used as a sub-technique by those who mainly use other techniques. Likewise, psychoanalytic psychotherapy, client-centered therapy and behavioral therapy are frequently used, respectively in the 30 to 40% use-frequency range. Other sub-techniques noted for frequent use are environmental manipulation (54.3%), family therapy (45.0%), autogenic training (39.7%), sand play therapy (39.2%) and play therapy (37.6%).

4) Relationship between main and sub-techniques

We examined the relationships between the four therapeutic techniques most frequently selected as the main techniques and the sub-techniques used by the same therapists who chose these main methods. Figure 3 illustrates the relationships between the techniques found by sorting out the chi-square test results. This figure indicates that client-centered therapy forms an independent technique group. Conversely, a significantly large number of psychotherapists who use behavioral therapy or eclectic psychotherapy as the main technique selected psychoanalytic psychotherapy as a sub-technique.

We examined the therapeutic techniques based on information provided by the subjects. We also analyzed more concrete aspects, particularly the therapist's behavior

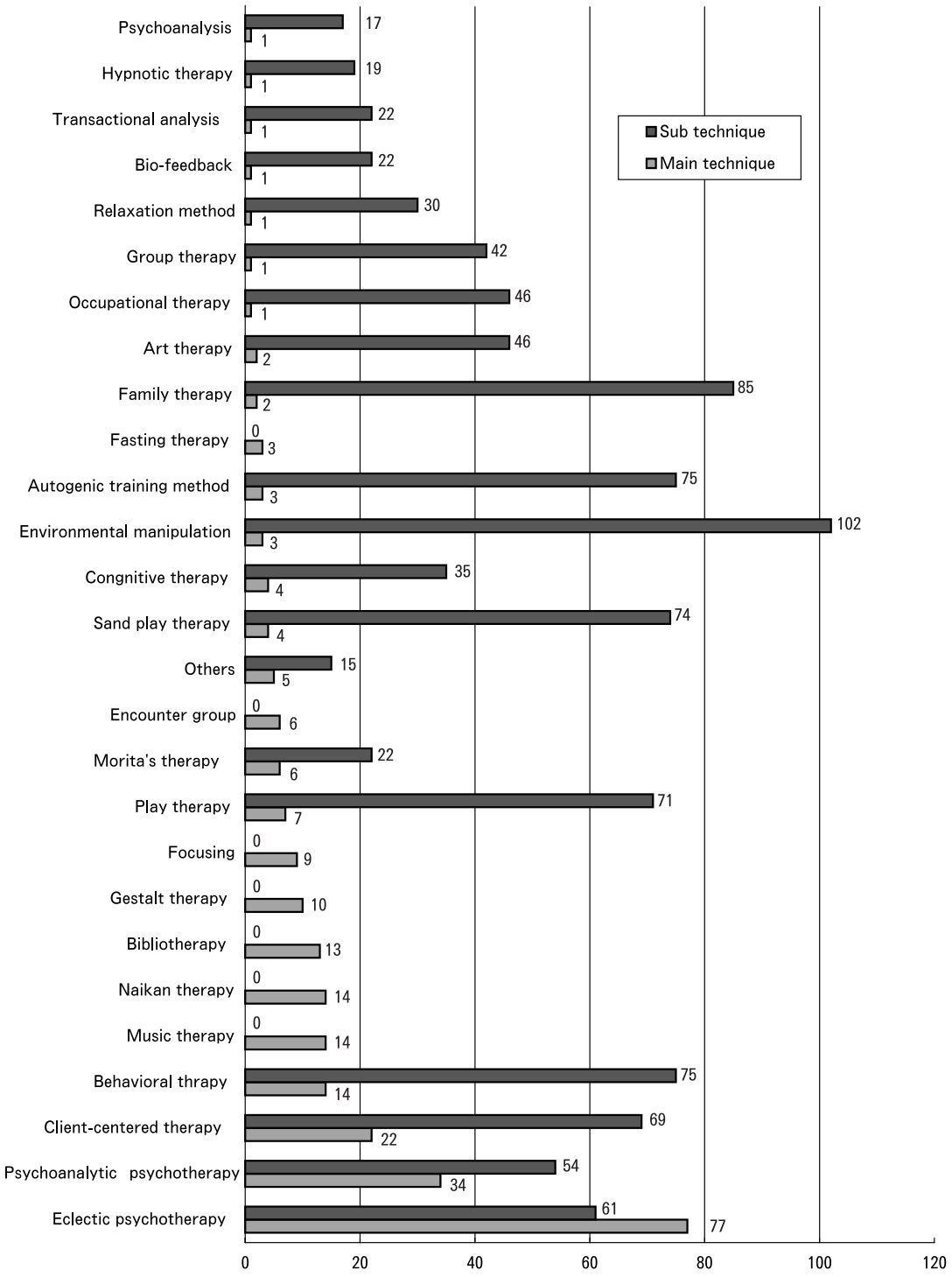

Fig. 2. Therapeutic trchniques used (n=189)

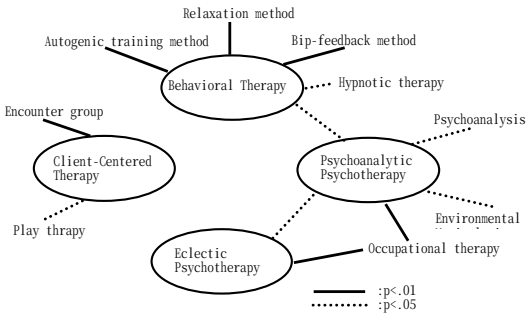

Fig. 3. Relationship between four Main Techniques and Sub Techniques (n=108)

and attitudes toward their everyday practice (contents of therapy).

5) Factor analysis of therapists' behavior and attitudes (contents of therapy)

A factor analysis was conducted with the principal factor method for 31 out of 45 items concerning how the therapists handle therapy sessions. The other 14 items were omitted due to their bias distribution. A factor analysis is a method to explain numerous variables by numerical potentiality factors. It is a method used to identify mutual relationships between variables. Table 2 is a fac-

Table 2. Four Factors In Therapists' Behavior and Attitudes in Psychotherapy

Factor 1 Framework for dynamic understanding	Ⅰ	Ⅱ	Ⅲ	Ⅳ
• Do you consider childhood experiences in the therapeutic process ?	0.74	−0	0.2	0.11
• Do you sometimes find the concept of the unconsciousness useful in therapy ?	0.7	−0.1	0.23	0.02
• Do you analyze transfer ?	0.67	−0.1	0.05	0
• Do you use approaches intended to make your patient recall his/her past experiences ?	0.66	−0	0.05	−0
• Do you take defense mechanisms into consideration during treatment ?	0.66	0.01	0.18	0.01
• Do you discuss past losses (or changes) of important human relationships with your patient ?	0.56	0.09	−0	−0.1
• Do you endeavor to mirror the patient's attitude and character rather than being your own self ?	0.32	−0.1	0.17	0.03
Factor 2 Activeness in therapy planning				
• Do you divide a grand goal into smaller steps ?	−0	0.77	−0	0.1
• Do you discriminate between intermediate and final targets ?	0.01	0.77	0.15	−0.1
• Do you discuss the purpose of the current session with your patient each time ?	−0	0.73	−0.1	0.05
• Do you summarize the important points of the session for your patient before closing each session ?	0.18	0.57	−0.2	0.03
• Do you take up specific topics in the proper order in therapeutic scenes ?	0.13	0.51	−0.1	0.06
• Do you carefully review your patient's irrational, subjective conviction (captive) and discuss it with him/her ?	0.06	0.51	−0.2	0.28
• Do you sometimes reward (by praise, tokens, articles, etc.) your patient ?	−0.1	0.4	−0.1	0.27
Factor 3 Directiveness in therapeutic management				
• Is it mainly you, the therapist, who does the talking during therapy ?	−0.2	0.18	0.6	0.17
• What is your attitudes towards the patient (1 : directive− 5 : receptive)?	−0.2	0.11	0.52	0.15
• Is it mainly you, the therapist, who changes the topic during therapy ?	−0.1	0.01	0.52	0.15
• Do you encourage your patient to come to his/her own conclusions and interpretations (1) or do you offer your own conclusions and interpretations (5)?	−0.1	0.4	0.41	0.25
• When there is a disagreement between you and your patient, do you often deny his/her opinion (1) or do you present another view without criticizing his/her opinion (5)?	0.08	0.12	0.32	−0
• Do you give concrete instructions to your patients ?	0.03	−0	−0.5	−0.1
• Do you direct your patient to avoid making serious decisions while undergoingtreatment ?	0.2	−0.1	−0.6	−0
Factor 4 Flexibility in the therapeutic relationship between the therapist and patient				
• Do you sometimes discuss non−urgent matters with your patient on the phone when you have time ?	0.09	0.1	−0.2	0.58
• Do you extend the regular interview time when the session is extraordinarilyproductive ?	−0.2	0.31	−0.2	0.47
• Do you answer personal questions (such as whether you are married, your family structure, age, years of experience) from your patients ?	−0.1	0.01	0.11	0.41
• Do you express personal feelings in front of your patient ?	0.16	0.09	−0.1	0.41
• Do you let your patient choose the weekly frequency of interview session if you have free time ?	0.03	0.14	−0.1	0.4
• Do you think that you can understand your patient well and provide him/her with more efficacious treatment if you have had similar experiences ?	0.04	0.06	0.07	0.38
• Do you make small talk (such as news, sports, movies) not directly related to treatment in therapeutic scene ?	−0.2	−0	−0.2	0.38
Eigen value	3.26	3.17	2.29	1.79
Contribution (%)	10.5	10.2	7.39	5.78

tor load matrix. This shows how each variable relates to each factor. Four factors (Ⅰ, Ⅱ, Ⅲ, Ⅳ) were extracted by varimax rotation of the factors with a 1 or greater Eigen value. The contribution ratio was 33.9 %, which explained a third of the variance. For each factor, the items included and having either +0.3 or greater factor loading or −0.3 or lesser factor loading, and the factor loading findings are listed in Table 2 along with the Eigen values of the four factors.

Four factors were adopted to facilitate comparisons with the results published in previous studies by McNaire and Wogan. The items were devided in 4 groups (Factors 1, 2, 3, 4), depending on the factor loading.

We named each factor based on a characteristic common to these variables.

Factor 1 was labeled as a "framework for dynamic understanding," because it represents an approach based on psychoanalytic theory, demonstrating a high load for such items as "Do you consider childhood experiences in the therapeutic process?" and "Do you sometimes find the concept of unconsciousness useful in therapy?"

In Factor 2, the items related to therapy planning and therapy targets showed a high factor load. These included "Do you divide a grand goal into small steps?" and "Do you discriminate between intermediate and final targets?" As a result, Factor 2 was labeled as "activeness in therapy planning." In Factor 3, the items with positive factor loadings include "Is It the therapist who mainly does the talking during therapy?" and "Is it mostly the therapist who changes the topic during therapy?" and those with a negative factor load include "Do you relate to the patient with a directive attitude or a receptive attitude?" Since this factor is interpreted as representing the therapists' levels of directiveness in actual therapy sessions, this factor was labeled as "directiveness in ˜therapeutic management."

Factor 4 had a high factor load with such items as "Do you sometimes discuss non-urgent matters with your patient on the phone when you have time?" and "Do you extend the regular interview time when the session is extraordinarily productive?" and "Do you answer personal questions from your patients?" This was labeled as "flexibility in the therapeutic relationship between the therapist and patient, because it is interpreted as representing a flexible behavior and attitudes of the therapists in accommodating therapeutic relationships to suit individual patients, instead of rigidly applying the framework of the therapeutic therapist-patient relationship.

6) Relationships between therapeutic techniques and therapists' behavior and attitudes. (contents of therapy)

Using use of the scores for the four factors obtained earlier in this study such as the indexes, we sought to identify relationships between the therapeutic techniques reported by the therapists themselves and their behavior and attitudes (contents of therapy). For this analysis, the subjects were limited to those (n=122) who had psychotherapy experience and use eclectic psychotherapy, psychoanalytic psychotherapy, client-centered therapy or behavioral therapy as the main technique.

A one-way factorial analysis of variance, regarding the main techniques was conducted for each of the four factors. The main effect of the therapeutic techniques was found in Factors 1, 2 and 3 respectively (Factor 1: $F(3, 114) = 26.36$, $p < .0001$; Factor 2: $F(3, 114) = 21.55$, $p < .0001$; Factor 3: $F(3, 114) = 12.83$, $p < .001$).

The results of a multiple comparisons test (Tukey method) were as follows.

For Factor 1, psychoanalytic psychotherapy scored significantly higher than the three other techniques ($p < .05$). Conversely, behavioral therapy scored significantly lower than the three other techniques, respectively ($p < .05$).

For Factor 2, a significant difference was noted between behavioral therapy and the three other therapeutic techniques.

For Factor 3, significant differences were noted between eclectic psychotherapy and psychoanalytic psychotherapy, between eclectic psychotherapy and client-centered therapy, respectively ($p < .05$).

For Factor 4, no significant differences were noted between the four main techniques.

Discussion

1. Techniques

While it is likely that every form of psychotherapy embodies both technical and interpersonal components to varying degrees, psychotherapists have traditionally asserted that the technical operations stressed by their particular "school" are the critical ingredients responsible for therapeutic change. We investigated how many techniques a therapist used in therapy. We discovered that each therapist employs 6 therapeutic techniques on average (6 ± 3.5), and that most therapists use several techniques according to each individual case. Psychotherapy is the execution of a practical scheme, and the therapist's role is to assist and treat those suffering from symptoms or having behavioral problems with the most efficacious methods. Therefore, a stereotyped application of a technique to all patients is practically inconceivable, and it would be more natural for therapists to have several techniques to choose from, depending on each individual case. Furthermore, one-on-one correspondence between the problem and technique, "technique B as the most appropriate therapeutic approach to problem A," is not easily applicable because the problems dealt with in therapy sessions are often so complicated or intricate that such correspondences do not readily work. It is thus likely that the problems presented by the patients spur the therapists on to acquire new techniques.

2. Factor analysis of therapists' behavior and attitudes (contents of therapy)

In the world of psychotherapy, the concepts of therapeutic goals and of procedures for bringing about therapeutic changes are diverse among different schools. However, no distinct consensus has yet been established concerning the therapists' roles and functions. In addition, the results of the analysis conducted so far in this study elucidated that individual member psychotherapists in a scientific society do not necessarily always use the therapeutic technique typical of that society.

Most psychotherapists have several techniques to choose from, out of necessity, to clinically deal with the psychopathological diversity among their patients.

In light of the foregoing, the classification of the contents of psychotherapists' treatment using the scientific societies of the subjects and their techniques as the only variables cannot provide a reliable base for scientific research of psychotherapy. We therefore believe that attempts to find a new classification base are called for.

In this section we conduct a factor analysis of the data from the questionnaire concerning how the therapists handle cases in therapy sessions. Thereafter, we discuss the relationships between the therapists' self-reported therapeutic techniques and their actual behavior and attitudes (contents of therapy) in therapy sessions in the subsequent section 3. Through a factor analysis using 31 Items concerning how therapists deal with cases in therapy sessions, four factors were extracted. Since there are few previous studies in Japan regarding an interpretation of these factors, we compared them with Western research results. Similar to our Factor 1 "framework for dynamic understanding" are "psychodynamic techniques" factor reported by Wogan and Norcross[7] and "factor A" by McNair and Lorr.[8] Similar factors to our Factor 2 "activeness in therapy planning" were also found by Wogan and Norcross[7] and by McNair and Lorr.[8] The former two labeled their factor as the "Planning Structuring" factor, as it consisted of items related to the planning and structuring of psychotherapy. The latter two named theirs "Factor D," as representing directive techniques, and they defined it as "techniques to plan a therapy, to actively execute the plan and to form therapeutic interaction in the direction determined by the therapist." This factor consisted of items identical to those contained in our Factor 2. Wogan and Norcross reported also a factor resembling our Factor 3 "directiveness in therapeutic management," which they named the "Direct Guidance" factor because it contains such items as giving direct guidance and advice to the patients.

To our Factor 4 "flexibility in the thera-

peutic relationship between the therapist and patient," a similar factor was extracted and labeled as "Maintenance of Personal Distance" by Wallach and Strupp.[9] The survey subjects for this study would be reasonably considered to be a group representing psychotherapists in Japan as they were sampled from the Japanese Society of Psychiatry and Neurology (roughly 6,700 members), Japanese Society of Clinical Psychologists (roughly 3,200 members), and Japanese Society of Behavioral Therapy (roughly 500 members).

The four factors extracted in this study, including the results of the comparative study with previous studies, would be considered to be valid factors reflecting the present status of psychotherapy in Japan.

3. Relationships between therapeutic techniques and therapists' behavior and attitudes (contents of therapy)

The results of this study are as follows:

1) While psychotherapists tend to frequently adopt a dynamic understanding framework, behavioral therapists are less likely to do so.
2) It has become clear that psychotherapists who mainly use behavioral therapy are more active in the therapy planning than are other psychotherapists.
3) Eclectic psychotherapists and behavioral therapists exercise higher levels of directiveness in interview management.

The above results indicate that three out of the four factors obtained by a factor analysis of therapists' behavior and attitudes (contents of therapy) are strongly related with the self-reported main techniques of the therapists. This study examined relationships only for the four techniques of eclectic psychotherapy, psychoanalytic psychotherapy, client-centered therapy and behavioral therapy. A similar examination of other techniques is called for in the future. Meanwhile, we believe that the four factors of the therapy contents extracted in this research are useful for categorizing psychotherapists and for also developing scientific, numerical studies of the effect of therapeutic techniques on the therapeutic process and the rate of successfully treated cases.

Conclusions

There have so far been very few research studies on psychotherapy. To gain an understanding of the present status of psychotherapy in Japan, we conducted a questionnaire-based survey on a total of 500 psychotherapists randomly sampled from psychiatrists and clinical psychologists engaged in psychotherapy. The response rate was 43.6%. The subjects actually included in the analysis numbered 128 psychiatrists, 80 clinical psychologists and 10 other therapists, thus totaling 218. The results were as follows: Four factors were extracted by a factor analysis of the collected data from questionnaire items designed to reflect the therapists' behavior and attitudes (contents of therapy) in their clinical practice. They included "framework for dynamic understanding" "activeness in therapy planning," "directiveness in therapeutic management," and "flexibility in the therapeutic relationship between therapist and patient."

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