

Individual Psychotherapy (“Talking Therapy”): A Survey of Attitudes among Residents & Specialists in Psychiatry, Israel 2010-2011

Orit Levi Shachar, MD,^{1,2,3} Shlomo Mendlovic, MD,^{1,2} Libi Hertzberg, MD, PhD,^{1,2,5} Yehuda Baruch, MD,^{1,4} and Ido Lurie, MD^{1,2}

¹ Sackler School of Medicine, Tel Aviv University, Tel Aviv, Israel

² Shalvata Mental Health Center, Hod Hasharon, Israel

³ Schneider Children's Medical Center, Petach Tikva, Israel

⁴ Abarbanel Mental Health Center, Bat Yam, Israel

⁵ Weizmann Institute of Science, Rehovot, Israel

ABSTRACT

Background: Individual psychotherapy is an efficient tool and an integral part of psychiatric treatment. However, its status among psychiatrists in Israel has never been explored.

Objectives: To explore and map the attitudes of psychiatrists in Israel regarding psychotherapy and psychotherapy training during residency, with comparisons between residents vs. specialists, peripheral vs. central institutions and mental health vs. medical centers.

Method: We conducted a cross-sectional survey to examine the attitudes toward individual psychotherapy. The questionnaire was delivered via email and direct approach to psychiatrists in Israel.

Results: The survey was completed by 229 of 1,502 registered psychiatrists (15.3%). While 96% (n=218) had positive attitudes towards psychotherapy, 93.1% (n=215) thought psychotherapy was less available than pharmacotherapy. Psychiatrists from peripheral institutions prefer cognitive behavioral therapy, while psychiatrists from central institutions prefer dynamic psychotherapy. Psychiatrists from mental health centers use more dynamic psychotherapy compared to psychiatrists from medical centers. The number of dynamic psychotherapy treatments psychiatrists delivered during their residencies has been decreasing over time, meaning residents today deliver fewer dynamic psychotherapy treatments compared to the number of treatments specialists delivered during their residencies. Additionally, 97.4% (n=225) believed

psychotherapy training should be included in the psychiatric residency and 87.3% thought that the training should be improved to a great extent.

Conclusions: The survey demonstrates mixed but overall positive attitudes towards psychotherapy among psychiatrists in Israel. The findings should be taken into consideration by psychiatrists who design the residency program and by policy makers who are in charge of the mental health reform in Israel, or the psychotherapy usage and therapeutic potential may diminish, as has happened in other countries.

INTRODUCTION

Individual psychotherapy is an important therapeutic tool for the psychiatrist as a mental health professional. The efficacy of psychotherapy has been demonstrated in various treatment modalities (1-3). Psychotherapy alone or combined with other therapeutic approaches is recommended by several psychiatric organizations in the guidelines for a number of psychiatric disorders (4-6).

Furthermore, psychotherapy has many benefits; it decreases psychiatric symptoms' severity and improves patients' coping and functioning (7). Psychotherapy for psychiatric inpatients has been shown to decrease psychological distress and physical complaints at discharge compared to admission to the hospital (8). Psychotherapy

also has cost benefits: It decreases the number of hospital admissions, hospitalization duration, sick leave from work, outpatient medical consultations, cost of therapists' time and medication use (7, 9, 10). Among psychiatry residents, psychotherapy training might improve their listening abilities and understanding of patients (11).

Over the years, trends have changed in conversational and pharmacological treatments. Several studies from the United States indicated a continuous decrease in the use of psychotherapy between the years 1985 and 2007, both as a single therapy and as a therapy combined with psychotropic medications. For example, the percentage of visits to psychiatric clinics involving psychotherapy as a single therapy declined from 15.9% in 1998 to 10.5% in 2007, and the number of visits involving psychotherapy combined with psychotropic medications declined from 40.0% in 1998 to 32.1% in 2007 (12-14).

Another change is the reduction of the duration of clinic-based psychiatry sessions; from an average of 42.8 minutes per session in 1985 to 38.1 minutes in 1995 (12). Accordingly, the national psychotherapy expenditure in the U.S. has also declined; the average expenditure per psychotherapy visit declined from \$122.80 in 1998 to \$94.59 in 2007, and the total national psychotherapy expenditure was reduced from \$10.94 billion in 1998 to \$7.17 billion in 2007 (14).

On the other hand, there was an increase in the use of psychotropic medications. The chance that a patient would receive a psychotropic medication almost doubled (from 31.5% in 1987 to 61.5% in 1997) (12). The use of psychotropic medication as a single therapy (without psychotherapy) increased from 44.1% in 1998 to 57.4% in 2007 (14). This trend was attributed to a wider selection of available psychotropic medications, with greater effectiveness, convenience of use, more rapid onset of action and fewer side-effects (15).

Due to the importance of psychotherapy, the European Board of Psychiatry, and the Accreditation Council for Graduate Medical Education (ACGME) in the U.S. determined that psychiatric residency programs should include training in psychotherapy, including clinical training (16, 17). Despite this requirement, a national survey conducted in the U.S. in 2004 among mental health caregivers, including psychiatrists, found that only some psychiatric residency programs met the requirements for both didactic and clinical supervision in psychotherapy; 28.1% met the requirements for evidence based therapies (e.g., behavioral therapy, CBT, dialectical behavior therapy (DBT)) and 45.6% for non-evidence based therapies (18).

Surveys regarding psychiatrists' attitudes toward psychotherapy in general and psychotherapy training in particular were conducted in several countries. In a survey conducted in England in 1996 among 149 psychiatrists, 20% believed that psychotherapy was an effective therapeutic tool, 20% believed that psychotherapy was not an effective therapeutic tool, and the rest were neutral. Most of the psychiatrists believed that psychotherapy training should be included in the psychiatric residency (19). In a survey conducted in the U.S. between 2006 and 2007 among 249 psychiatry residents, 56% of the residents thought their residency provided high-quality training in psychotherapy, and 64.2% thought they received excellent supervision on their psychotherapy cases. Only 3.5% of the residents thought there was a general negative attitude towards psychotherapy in their training program, and only 27.7% believed that their program did not allocate sufficient time or resources for psychotherapy training (20). In another study from the U.S., more positive attitudes towards psychotherapy among psychiatry residents were associated with higher competency in psychotherapy (21).

In Israel also, psychotherapy training is included in the psychiatric residency requirements (22). To the best of our knowledge, to date, no survey has been conducted among psychiatry residents and specialists in Israel regarding their attitudes toward psychotherapy. This survey has a great importance both regarding the residency program in psychiatry and inclusion of psychotherapy as one of the services available for mental health caregivers. Results of this survey can affect the reform in the mental health services.

The objectives of the survey were to map the attitudes of psychiatry residents and specialists in Israel toward psychotherapy and psychotherapy training during residency, with comparisons between residents vs. specialists, peripheral vs. central institutions (according to geographical location), and mental health centers (specialized psychiatric hospitals) vs. medical centers (e.g., general hospitals).

METHODS

SAMPLE

The study was a cross-sectional survey conducted among residents and specialists in psychiatry in Israel, according to registration of the psychiatry residents' organization (240 residents with listed e-mail addresses) and of the Israel Medical Association (IMA) (1,262 registered specialists; 748 of whom with listed e-mail addresses) between November 2010 and July 2011.

PROCEDURE

The questionnaires were distributed electronically by e-mails and manually during psychiatry conventions and at mental health centers. The electronic and the manual versions were identical and both contained an informed consent form for participation in the survey. A letter from chairperson of the Israel Psychiatric Association encouraging participation in the survey accompanied the survey forms. The first email to the psychiatry residents' organization was sent in 22/11/2010 and the first email to the IMA was sent in 12/12/2010. Follow-up e-mails were sent to encourage response; in 17/5/2011 to the psychiatry residents' organization and in 27/6/2011 to the IMA. The survey was authorized by the Institutional Review Board of Abarbanel Mental Health Center.

SURVEY DOMAINS

The questionnaire included three main sections: (a) demographic details (e.g., gender, age) and questions assessing the extent of clinical experience and psychotherapy training of the respondents (e.g., do the respondents receive psychotherapy supervision from a senior psychiatrist, preferences toward consecutive/ exchangeable supervision); (b) clinical vignettes with *multiple* choice questions regarding treatment options for the patients depicted in the vignettes, and (c) statements exploring attitudes toward various issues in psychotherapy including: psychotherapy in general and self-preferences, its availability as a therapeutic tool in the workplace and the quality of psychotherapy training during residency. The statements were graded using a Likert scale (1=strongly disagree, 5=strongly agree). In addition, a list of items exploring the availability of professional knowledge in psychotherapy in the workplace using a scale of 1 to 3 (1=more than adequate, 3=less than adequate), and subjective self-appraisal of the level of theoretical knowledge and clinical skills in psychotherapy using a Likert scale (1=very low, 5=very high). The survey concluded with an open question asking respondents to provide general comments about psychotherapy training at their institution.

The questionnaire is available from the corresponding author upon request.

DATA ANALYSIS

Data from the electronic version and the manual version were collected and analyzed using SAS version 9.1.

Theoretical statistics: Continuous variables were displayed using sample size, average, standard deviation (SD) and minimum and maximum values. Categorical variables

were displayed using group size and frequency observed in percentages.

Statistical tests: Differences between continuous variables were analyzed using t-test for independent samples. Differences between three groups or more of continuous variables were analyzed using one way ANOVA. Sequel tests between groups' couples were conducted for further testing the source of significance. Dependence between two categorical variables was examined using chi-square test. Association between two continuous variables was examined using Pearson's correlation coefficient. All tests were two-tailed. For level of significance the alpha used was 0.05. The reliabilities of the 5-point rating scale items and 3-point rating scale items were examined using Cronbach's alpha for questionnaire internal consistency test. Items were reverse scaled as appropriate for consistent direction in analysis.

RESULTS

RESPONSE RATE AND DEMOGRAPHIC CHARACTERISTICS

The total sample included 229 respondents, with a response rate of 15.2%. Table 1 shows participants' characteristics. Of the 1,262 specialists registered in the IMA, a total of 157 specialists completed the survey (12.4%): 131 (10.4%) answered the electronic version and 26 (2.1%) answered the manual version. Of the 240 residents registered in the psychiatry residents' organization, a total of 72 residents (30.0%) completed the survey: 49 (20.4%) answered the electronic version and 23 (9.6%) answered the manual version. The number of psychiatrists who received the manual version was not known, and therefore it was not possible to estimate the response rate for the manual format.

Sex distribution of specialists listed in the IMA was 41.0% (n=517) men and 59.0% (n=745) women, while in our survey, the majority of the specialists were men (60.5%). (Table 1). Of the 1,262 specialists listed in the IMA, 33.4% (n=422) gained their medical education in Israel, 60.3% (n=761) abroad and 6.3% (n=79) unknown. In the survey, the majority of specialists gained their medical education in Israel (63.1%) (Table 1). No other demographic characteristics of the specialists were available in the IMA registry.

In the survey, there were 36.1% (n=26) senior residents (those who passed Part I examination) and 63.9% (n=46) junior residents (those who did not pass/take Part I examination). Residents' demographic characteristics were not available in the registry of the residents' organization.

We found that peripheral institutions employ significantly

Table 1. Participants' Demographic Characteristics (N=229)^a

Characteristic	Residents		Specialists		Analysis		
	N (72)	% (31.4%)	N (157)	% (68.6%)	χ^2	df	P
Sex							
Men	30	41.7	95	60.5	7.83	2	0.02
Women	42	58.3	61	38.9			
Age (years)					97.04	5	<0.0001
25-35	40	55.6	5	3.2			
36-45	25	34.7	61	38.8			
46-55	6	8.3	45	28.7			
56-65	1	1.4	37	23.6			
≥66	0	0.0	8	5.1			
Country of birth					4.71	3	0.19
Israel	49	68.1	85	54.1			
Eastern Europe Other	15 7	20.8 9.7	45 26	28.7 16.7			
Country of medical school					1.73	3	0.63
Israel	45	62.5	99	63.1			
Eastern Europe Other	19 6	26.4 8.3	36 20	22.9 12.7			
Institute of residency (by region)^b					1.24	1	0.27
Center Periphery	59 9	86.8 13.2	116 28	80.6 19.4			
Institute of residency (by type)^c					0.10	1	0.75
Medical Center Mental Health Center	17 51	25.0 75.0	39 105	27.1 72.9			
Seniority (in years)					143.78	3	<0.0001
0-5	47	67.1	0	0.0			
5-10	17	24.3	38	24.5			
10-20	4	5.7	54	34.8			
>20	2	2.9	63	40.7			

^aNumbers do not always add up to 229 due to missing responses for some of the items.

^bFor the list of central vs. peripheral institutes, please see appendix 1.

^cFor the list of medical vs. mental health centers, please see appendix 1.

more psychiatrists who were born in Eastern Europe or who gained their medical education there: Of 37 respondents from peripheral institutions (each time the text refers to respondents from peripheral or central institutions, the meaning is respondents who did/do their residency in peripheral or central institutions respectively), 48.6% (n=18) were born in Eastern Europe compared to 19.4% (n=34) of respondents from central institutions ($\chi^2=14.81$, $df=3$, $p=0.002$). Similarly of those 37 respondents, 48.6% (n=18) gained their medical education in Eastern Europe compared to 17.1% (n=30) of respondents from central institutions ($\chi^2=18.17$, $df=3$, $p=0.0004$). There was no significant difference in country of birth and country of medical school between mental health centers vs. medical centers (each time the text refers to respondents from mental health centers or medical centers, the meaning is respondents who did/do

their residency in mental health centers or medical centers respectively).

PSYCHOTHERAPY CLINICAL EXPERIENCE AND TRAINING

Psychotherapy Supervision

Several parameters regarding psychotherapy training during the residency were examined. The first was whether the psychiatrists received psychotherapy supervision by a senior psychiatrist. Of the residents, 75.0% (n=54) received supervision and 25.0% (n=18) did not, compared to 64.3% (n=101) of the specialists who received psychotherapy supervision and 35.7% (n=50) who did not ($\chi^2=37.69$, $df=2$, $p<0.0001$). There was no significant difference between mental health centers vs. medical centers or between central institutions vs. peripheral institutions.

Of the residents who received psychotherapy supervision, 79.2% (n=42) had supervision once a week, 15.1% (n=8) had supervision once every two weeks or less and 5.7% (n=3) more than once a week. Of the specialists who received psychotherapy supervision, 61.7% (n=29) had supervision once a week, 34.0% (n=16) had supervision once every two weeks or less and 4.3% (n=2) more than once a week ($\chi^2=4.90$, $df=2$, $p=0.09$).

Psychotherapeutic Treatments during Residency

The survey examined a) whether psychiatrists delivered psychotherapeutic treatments during their residencies, and if so, b) how many treatments and c) what type of psychotherapy.

Of the residents, 84.7% (n=61) delivered psychotherapeutic treatments during their residencies and 15.3% (n=11) did not, compared to 99.3% (n=151) of specialists who delivered psychotherapeutic treatments during their residencies and 0.7% (n=1) who did not ($\chi^2=20.60$, $df=1$, $p<0.0001$). When examining the residents' group separately, 76.1% (n=35) of the junior residents delivered psychotherapeutic treatments during their residencies and 23.9% (n=11) did not, compared to 100% (n=26) of the senior residents who delivered psychotherapeutic treatments during their residencies ($\chi^2=7.34$, $df=1$, $p=0.007$).

The average number of dynamic psychotherapy treatments during the residency was higher among specialists compared to residents; average of 6.1 and 3.5 respectively ($t=-4.28$, $df=151$, $p<0.0001$). The average number of dynamic psychotherapy treatments during the residencies was also higher among senior residents compared

to junior residents; average of 4.7 and 2.7 respectively ($t=-2.00$, $df=34$, $p=0.05$).

Moreover, the average number of dynamic psychotherapy treatments during residency increased with seniority; psychiatrists who did their residencies in recent years delivered fewer dynamic psychotherapy treatments during their residencies compared to psychiatrists who did their residencies in previous years ($F=11.40$, $df=3$, $p<0.0001$). In the case of CBT and hypnosis there was no significant difference (Graph 1).

For all three psychotherapy modalities examined (dynamic psychotherapy, CBT, hypnosis) there was no significant difference between central institutions vs. peripheral institutions or between mental health centers vs. medical centers.

Psychotherapeutic Treatments Delivered during the Survey

The survey examined a) whether psychiatrists delivered psychotherapeutic treatments at the time of the survey, and if so, b) how many treatments and c) what type of psychotherapy.

Of the residents, 66.7% ($n=48$) delivered psychotherapeutic treatments at the time of the survey and 33.3% ($n=24$) did not, compared to 85.3% ($n=133$) of the specialists who delivered psychotherapeutic treatments and 14.7% ($n=23$) who did not ($\chi^2=10.63$, $df=1$, $p=0.001$).

The average number of treatments delivered at the time of the survey was also significantly higher for specialists in comparison to residents in all three modalities; in the case of dynamic psychotherapy average of 3.9 and 2.0 respectively ($t=-4.43$, $df=161$, $p<0.0001$); in the case of CBT average of 2.5 and 0.8 respectively ($t=-3.51$, $df=134$, $p=0.0006$); in the case of hypnosis average of 0.4 and 0 respectively ($t=-2.18$, $df=110$, $p=0.03$). There was no significant difference between junior residents and senior

residents in the average number of treatments delivered at the time of the survey in all three modalities.

Respondents from peripheral institutions used more CBT than respondents from central institutions at the time of the survey; average of 4.5 vs. 1.6 treatments respectively ($t=-2.07$, $df=25$, $p=0.049$). Respondents from central institutions used more dynamic psychotherapy than respondents from peripheral institutions at the time of the survey; average of 3.7 vs. 2.3 treatments respectively ($t=2.50$, $df=63$, $p=0.01$). There was no significant difference in the use of hypnosis. Respondents from mental health centers used more dynamic psychotherapy compared to respondents from medical centers at the time of the survey; average of 3.9 vs. 2.3 treatments respectively ($t=-3.23$, $df=135$, $p=0.001$). There was no significant difference in the use of CBT and hypnosis. There was a correlation between the number of treatments specialists delivered during their residencies and the number of treatments they delivered during the time of the survey (CBT: $r_p=0.50$, $df=99$, $p<0.0001$; hypnosis: $r_p=0.46$, $df=93$, $p<0.0001$). No correlation was found in the use of dynamic psychotherapy.

Self-Psychotherapy Treatment

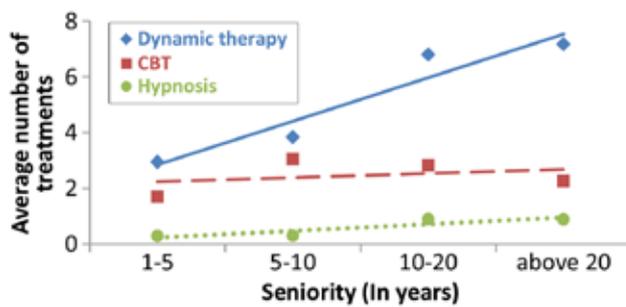
Of the residents, 65.3% ($n=47$) reported they received self-psychotherapy treatment and 34.7% ($n=25$) did not, compared to 77.7% ($n=122$) of the specialists who reported they received self-psychotherapy treatment and 21.0% ($n=33$) who did not ($\chi^2=5.61$, $df=2$, $p=0.06$). There was no significant difference between central institutions vs. peripheral institutions or between mental health centers vs. medical centers. The most common psychotherapy was dynamic psychotherapy, reported by 96.4% ($n=163$) of the respondents.

Self-Reported Knowledge and Clinical Skills

The average self-reported grade of theoretical knowledge in psychotherapy was 2.6 for residents and 3.6 for specialists ($t=9.28$, $df=227$, $p<0.0001$). The average self-reported grade of clinical skills in psychotherapy was 2.5 for residents and 3.6 for specialists ($t=9.77$, $df=227$, $p<0.0001$). There was no significant difference between central institutions vs. peripheral institutions or between mental health centers vs. medical centers.

Respondents who received self-psychotherapy treatment reported higher scores for knowledge in psychotherapy compared to those who did not; 3.5 and 2.9 respectively ($t=2.38$, $df=225$, $p<0.0001$). Additionally, they reported higher scores for clinical skills in psychotherapy; 3.3 and 2.8 respectively ($t=3.26$, $df=225$, $p=0.002$).

Graph 1. Average Number of Treatments during Residency in Different Modalities According to Seniority



ATTITUDES TOWARDS PSYCHOTHERAPY AND PSYCHOTHERAPY TRAINING

Clinical Vignettes

Three multiple choice clinical vignettes were depicted. In the first two vignettes, the respondents had to choose their preferred first and only therapeutic treatment. The results were similar for both vignettes; approximately 75% chose psychotherapy (of various modalities), 10% chose psychotropic drugs and 15% chose another option, not offered by us, that did not fit the two categories listed above. The two psychotherapies most chosen in the first vignette, of those who chose psychotherapy, were crisis intervention/supportive psychotherapy (47.6%, $n=109$) and dynamic psychotherapy (19.7%, $n=45$). Respondents with less seniority tended more toward supportive therapy and respondents with more seniority preferred dynamic psychotherapy ($F(6,161)=2.78$, $p=0.01$).

In the second vignette the psychotherapies chosen were more diverse; 24.0% ($n=55$) chose dynamic psychotherapy, 21.4% ($n=49$) chose hypnosis, 19.2% ($n=44$) chose CBT and 8.7% ($n=20$) chose supportive psychotherapy/crisis intervention. Residents favored supportive psychotherapy/crisis intervention and specialists tended to prefer dynamic psychotherapy ($\chi^2=11.06$, $df=4$, $p=0.02$). There was no significant difference between central institutions vs. peripheral institutions or between mental health centers vs. medical centers.

In the third vignette respondents had to decide whether the patient depicted could benefit from psychotherapy; 99.1% ($n=227$) answered that he could and 0.9% ($n=2$) answered that he could not. The preferred psychotherapy was supportive psychotherapy (37.0%, $n=84$). In the periphery there was a tendency toward insight oriented psychotherapy (46.9%, $n=15$), while in the center there was a tendency toward supportive psychotherapy (40.7%, $n=70$) ($\chi^2=17.41$, $df=6$, $p=0.008$). There was no significant difference between residents vs. specialists or between mental health centers vs. medical centers.

STATEMENTS

Attitudes towards psychotherapy and self-preferences. *Cronbach's alpha* for this group was 0.68. Of the respondents, 95.7% ($n=218$) had positive opinions of psychotherapy in general, 3.9% ($n=9$) were neutral and 0.4% ($n=1$) had negative opinions. Psychiatrists from central institutions had more positive opinions of psychotherapy compared to psychiatrists from peripheral institutions; average grade of 4.4 and 4.2 respectively ($t=2.20$, $df=210$, $p=0.03$). Also, psychiatrists who received self-psychotherapy treatment

had more positive opinions of psychotherapy compared to those who did not; average grade of 4.4 and 4.1 respectively ($t=3.52$, $df=225$, $p=0.001$). There was no significant difference between residents and specialists or between mental health centers vs. medical centers.

Opinions regarding psychotherapy's effectiveness compared to psychotropic drug efficacy were less decisive, likewise for the statement "Biological treatments are more effective than non-biological treatments" 39.6% ($n=61$) chose to be neutral, 35.7% ($n=55$) disagreed with the statement and 24.7% ($n=38$) agreed with the statement.

Quality of psychotherapy training during residency. *Cronbach's alpha* for this group was 0.62. Of the respondents, 45.0% ($n=103$) had negative opinions of psychotherapy training, 30.1% ($n=69$) were neutral and 24.9% ($n=57$) had positive opinions. Specialists had more positive opinions of psychotherapy training compared to residents; average grade of 3.0 and 2.6 respectively ($t=-3.17$, $df=227$, $p=0.002$). There were no significant differences between central institutions vs. peripheral institutions or between mental health centers vs. medical centers.

Of the residents, those who received psychotherapy supervision had significantly more positive opinions of psychotherapy training compared to those did not; average grade of 2.7 and 2.2 respectively ($t=-0.84$, $df=70$, $p=0.02$).

Regarding the question "to what extent would you improve the training in psychotherapy," 87.3% ($n=200$) thought it should be improved to a great extent, 8.3% ($n=19$) thought it should be improved to a small extent and 4.4% ($n=10$) thought it did not require any change. Residents thought psychotherapy training should be improved to a greater extent compared to specialists; average grade of 4.2 and 3.9 respectively ($t=2.14$, $df=227$, $p=0.03$). There was no significant difference between central institutions vs. peripheral institutions or between mental health centers vs. medical centers.

Regarding what type of psychotherapy supervision the respondents preferred, 58.8% ($n=110$) said they prefer consecutive supervision and 41.2% ($n=77$) said they prefer exchangeable supervision, with no difference between residents and specialists.

Psychotherapy availability in the workplace. *Cronbach's alpha* for this group was 0.58. Of the respondents, 58.8% ($n=133$) thought psychotherapeutic treatments were not available in their workplace, 18.1% ($n=41$) were neutral and 23.0% ($n=52$) thought they were available. Respondents from medical centers thought psychotherapeutic treatments were less available in their workplace compared to respondents from mental health centers; average grade

of 3.7 and 3.3 respectively ($t=-2.79$, $df=208$, $p=0.006$). In addition, respondents who had 0-10 years of experience thought psychotherapeutic treatments were less available in their workplace compared to respondents who had 20 years of experience ($F(5,219)=3.91$, $p=0.002$). There was no significant difference between central institutions vs. peripheral institutions.

Psychotherapy professional knowledge availability in the workplace. Cronbach's α for this group was 0.80. Of the respondents, 56.1% ($n=111$) thought professional knowledge in psychotherapy (i.e., professional journals, seminars, staff meetings, journal clubs and research) in their workplace was less than adequate, 40.9% ($n=81$) thought the knowledge was adequate and 3.0% ($n=6$) thought the knowledge was more than adequate. There was no significant difference between residents vs. specialists, central institutions vs. peripheral institutions or mental health centers vs. medical centers.

The entire list of statements and answers is available from the corresponding author upon request.

DISCUSSION

This study is the first designed to examine the attitudes of psychiatry residents and specialists in Israel regarding psychotherapy in general and psychotherapy training during psychiatric residency in particular. The survey used several parameters to determine these attitudes and to reflect the status of the psychotherapy experience and training.

The survey indicated that the majority of psychiatrists in Israel have positive attitudes toward psychotherapy in general. They think that psychotherapy should be used as a therapeutic tool in the psychiatric setting, and they would like to use it more often than they did at the time of the survey. Almost all respondents thought that there are some psychiatric diagnoses in which psychotherapy is preferable over psychotropic drugs. However, when asked explicitly on the effectiveness of psychotherapy compared to psychotropic drugs, the answers were less decisive, and a substantial proportion of the respondents chose to be neutral. Although respondents had difficulties deciding on the effectiveness of psychotherapy, when they were presented with clinical vignettes, most of them chose psychotherapy as the first and only therapeutic step, which further emphasizes psychiatrists' willingness to use psychotherapy.

Those who received self-psychotherapy treatment had more favorable attitudes toward psychotherapy compared to those who did not, although the difference was minor. In addition, respondents who received self-psychotherapy

treatment reported higher levels of knowledge and clinical skills in psychotherapy compared to those who did not. These results are similar to those of a survey conducted in the U.S. that also indicated that residents who received self-psychotherapy treatment had more favorable attitudes toward psychotherapy and were more enthusiastic about using it in the future (23). There was also a negligible difference in the attitudes toward psychotherapy between psychiatrists from central institutions and psychiatrists from peripheral institutions.

Apparently, psychiatrists would like to use psychotherapy. However, the majority of the respondents thought that pharmacotherapy was more readily available, and that the professional knowledge in psychotherapy in their workplace was less than adequate. Also, the majority of the respondents thought that the time frame allocated for meeting patients in their workplace did not enable psychotherapy, and that the psychotherapeutic treatments in their workplace were performed mainly by psychologists and/or social workers and not by psychiatrists. According to the Annual Mental Health Report of the Israel Mental Health Department, there was a decrease in the work positions allocated to mental health services by the Ministry of Health, from 16.4% in 1996 to 13.3% in 2005. There was also a decrease in the budget allocated to inpatient hospitalization from the entire mental health budget from 79.0% in 1996 to 63.1% in 2005 (24). This trend may affect the choice of treatments in psychiatric facilities, including focusing on more immediate treatments such as psychopharmacology as opposed to psychotherapeutic treatments which require longer hospitalizations. As mentioned before, studies from the U.S. demonstrated a decline in the psychotherapy treatments given by psychiatrists and a rise in the use of psychotropic drugs (12-14). A review article regarding psychotherapy and mental health compared the situation in Israel and in the U.S. The author concluded with a warning, as the situation in Israel may follow the footsteps of U.S. (25)T.</author></authors></contributors><auth-address>Western Galilee Community Mental Health Clinics, Fligelman Mazra Psychiatric Hospital, Acre, Israel. tsvigil@bezeqint.net</auth-address><titles><title>Psychiatry and psychotherapy in the managed care era: present and future in Israel and learning from the American experience (in Hebrew.

It is also possible that specializing in psychopharmacological therapy has led to a situation in which in some psychiatric settings psychiatrists mainly prescribe medications while psychologists or social workers offer psychotherapy, as 66% of the psychiatrists who answered the survey agreed with this statement.

The use of psychotherapy varies among the different institutions. Psychiatrists from peripheral institutions prefer using CBT, while psychiatrists from central institutions prefer using dynamic psychotherapy. It is possible that the shortage of psychiatrists in the periphery (26) The Departments of Health Economics and Insurance, Israel Ministry of Health (in Hebrew led to a preference for CBT in the periphery, which is a shorter and more focused treatment, compared to dynamic psychotherapy. Psychiatrists from mental health centers use more dynamic psychotherapy compared to psychiatrists from general medical centers.

Almost all respondents believed that psychotherapy should be a part of the psychiatric residency program. Most respondents thought that during residency the emphasis was placed on pharmacological treatments and would like to focus more on psychotherapy. Furthermore, most respondents thought psychotherapy training needs considerable improvement. From a residents' survey conducted in 2010 in the U.S. it seems that residents were more content with their psychotherapy training compared to the residents in Israel; only 27.7% of the residents thought that the residency program did not allocate sufficient time and resources for psychotherapy training and most of them (56%), thought their residency training program provided high-quality training in psychotherapy (20).

As previously noted, in Europe, the U.S. and Israel the psychiatric residency program mandates both psychotherapy clinical exposure and supervision as part of the psychiatric residency requirements (16, 17, 22) Israel Psychiatric Association (in Hebrew. Despite that requirement, one quarter of the residents in Israel reported they did not receive psychotherapy supervision. In surveys conducted among psychiatry residents in Israel, the U.S. and England, the residents chose "quality of supervision" as the most important factor in determining their satisfaction with the psychotherapy training they received during residency (19, 27, 28). This emphasizes the importance of high-quality psychotherapy supervision during the residency.

The majority of respondents preferred consecutive supervision. The reasons mentioned are: profound relationship with the supervisor, process continuity, the ability to elaborate and become immersed in the treatment and more efficient use of time. Respondents who argued against consecutive supervision said it was enriching to learn different approaches and points of view and that in the event that the supervisor was not adequately skilled, or the relationship with the supervisor was not good, it was better to have the option of additional supervisors.

In addition, 15% of the residents reported they had not delivered any psychotherapeutic treatment from when their residency began until the date of the survey. Although they were all junior residents, all but two had at least two years of experience and all had completed a rotation in a major department (closed, open or adolescent wards).

The average number of dynamic psychotherapy treatments delivered during residency was higher among senior residents compared to junior residents and also higher among specialists compared to junior residents. Although the average number of dynamic psychotherapy treatments delivered during residency did not differ between senior residents and specialists, we did find that across time the average number of dynamic psychotherapy treatments during residency increased with seniority. Furthermore, in two clinical vignettes presented in the survey, respondents with less seniority tended to choose supportive psychotherapy while respondents with more seniority tended to choose dynamic psychotherapy, which may indicate a lack of skills or confidence in this modality among the residents. The subjective report also differed between residents and specialists: specialists had more positive opinions toward psychotherapy training during their residency compared to residents. It seems that there is currently less emphasis on psychotherapy in general and on dynamic psychotherapy in particular.

Our study has several limitations. The overall response rate was 15.2%, which is low, so the study's external validity cannot be evaluated. The residents the response rate was 30%, while the specialists' response rate lowered the overall rate. It is possible that some e-mail addresses listed in the IMA and the psychiatry residents' organization were incorrect. The number of psychiatrists listed in the IMA is not updated and includes retired psychiatrists. Past surveys have shown them to be consistently poor responders, compared to other populations (29). Several studies demonstrated that online surveys have lower response rate compared to paper based surveys, ranging between 20%-40% (29-32). Further, the response rate to online surveys have declined over the last years, from average response rate of 61.5% in 1986 to 24.0% in 2000 (33). Another possible explanation for the low response rate could be the length of the questionnaire. However, studies failed to demonstrate association between the length of the survey and the response rate (32).

Residents' demographic characteristics were not available from the registry of the residents' organization. Likewise, the only data available regarding the specialists' distribution as listed in the IMA was their gender and whether their medical education was in Israel or abroad. In the survey, the sex distribution was opposite to that in the IMA registry.

Similarly, the specialists who answered the survey, 64% gained their medical education in Israel and 35% abroad, while the distribution in the IMH was almost opposite. These differences make it difficult to know whether the sample represents the overall population. Furthermore, nearly 30% of the respondents, residents or specialists, did their residency in two large mental health centers. Also, there were only 37 respondents from peripheral institutions. It is possible that psychiatrists who completed the survey had more positive attitudes toward psychotherapy in the first place, while those who had more negative attitudes toward psychotherapy chose not to participate in a survey on the subject of psychotherapy (selection bias).

Respondents had to indicate data regarding their residency (e.g. the number of psychotherapeutic treatments during residency, satisfaction with the residency), and it is possible that the more positive opinions specialists had about their residencies were a result of recall bias. Also, these trends were not examined along several years, but rather at a specific point in time, as the methodology was designed as a cross sectional survey. Finally, the questionnaire included information concerning the institution where residency was done, but did not contain information about the current workplace.

In conclusion, respondents had positive attitudes toward psychotherapy in general but concerns were raised regarding its availability in medical and mental health institutions and the ability to actually use it. Psychotherapy treatments are an important and efficient tool of psychiatrists. In order for psychotherapy that its use increases rather than decreases as in the U.S., these findings should be taken into a greater consideration in light of the mental health reform in Israel.

Almost all participants agreed that psychotherapy should be included in the psychiatric residency program. Most respondents thought that psychotherapy training should be considerably improved and that more time should be allocated to training. Given the current residency training requirements and the finding that one quarter of the residents did not receive psychotherapy supervision, re-evaluation of the quality and quantity of resources devoted to psychotherapy training in residency programs is warranted.

References

- Leichsenring F, Rabung S. Effectiveness of long-term psychodynamic psychotherapy: A meta-analysis. *JAMA* 2008;300:1551-1565.
- Leichsenring F, Rabung S, Leibing E. The efficacy of short-term psychodynamic psychotherapy in specific psychiatric disorders: A meta-analysis. *Arch Gen Psychiatry* 2004;61:1208-1216.
- Butler AC, Chapman JE, Forman EM, Beck AT. The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clin Psychol Rev* 2006;26:17-31.
- Practice guideline for the treatment of patients with major depressive disorder (revision). American Psychiatric Association. *Am J Psychiatry* 2000;157:1-45.
- Koran LM, Hanna GL, Hollander E, Nestadt G, Simpson HB. Practice guideline for the treatment of patients with obsessive-compulsive disorder. *Am J Psychiatry* 2007;164:5-53.
- Ursano RJ, Bell C, Eth S, Friedman M, Norwood A, Pfefferbaum B, et al. Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder. *Am J Psychiatry* 2004;161:3-31.
- Lambert MJ. Bergin and Garfield's handbook of psychotherapy and behavior change. 5th ed. Michael J. Lambert, editor. Hoboken, N.J.: Wiley, 2004.
- Beutel ME, Hoflich A, Kurth RA, Reimer C. Who benefits from inpatient short-term psychotherapy in the long run? Patients' evaluations, outpatient after-care and determinants of outcome. *Psychol Psychother* 2005;78:219-234.
- Gabbard GO, Lazar SG, Hornberger J, Spiegel D. The economic impact of psychotherapy: A review. *Am J Psychiatry* 1997;154:147-155.
- Saskia de Maat P, Philipszoon F, Schoevers R, Dekker J, De Jonghe F. Costs and benefits of long-term psychoanalytic therapy: Changes in health care use and work impairment. *Harv Rev Psychiatry* 2007;289-300.
- Shalev AY. Teaching psychotherapy to psychiatric residents in Israel. *Isr J Psychiatry Relat Sci* 2007;44:167-175; discussion 75-77.
- Olsson M, Marcus SC, Pincus HA. Trends in office-based psychiatric practice. *Am J Psychiatry* 1999;156:451-457.
- Mojtabai R, Olsson M. National trends in psychotherapy by office-based psychiatrists. *Arch Gen Psychiatry* 2008;65:962-970.
- Olsson M, Marcus SC. National trends in outpatient psychotherapy. *Am J Psychiatry* 2010;167:1456-1463.
- Keith S. Advances in psychotropic formulations. *Prog Neuropsychopharmacol Biol Psychiatry* 2006;30:996-1008.
- ACGME Program Requirements for Graduate Medical Education in Psychiatry. http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/400_psychiatry_07012014.pdf. 2007.
- European Board of Psychiatry: Requirements for specialist training in psychiatry. Document of the European Board of Psychiatry, 1997.
- Weissman MM, Verdelli H, Gameraff MJ, Bledsoe SE, Betts K, Mufson L, et al. National survey of psychotherapy training in psychiatry, psychology, and social work. *Arch Gen Psychiatry* 2006;63:925-934.
- Bradbury S OBL, Gopfert M. Psychotherapy - a survey of psychiatrists' attitudes, beliefs and practice. *Psychiatric Bulletin* 1996;20:15-19.
- Calabrese C, Sciollo A, Zisook S, Bitner R, Tuttle J, Dunn LB. Psychiatric residents' views of quality of psychotherapy training and psychotherapy competencies: A multisite survey. *Acad Psychiatry* 2010;34:13-20.
- Coon KA, Yates WR, Touchet BK, Lund B. A pilot study of psychiatry resident psychotherapy competency: The impact of resident attitude and demographics. *Am J Psychother* 2006;60:175-185.
- The psychiatry residency program, Israel Psychiatric Association (in Hebrew) <http://www.ima.org.il/Ima/FormStorage/Type7/cylabusKidsandAdolePsychiatry2009.pdf>. 2009.
- Lanouette NM, Calabrese C, Sciollo AF, Bitner R, Mustata G, Haak J, et al. Do psychiatry residents identify as psychotherapists? A multisite survey. *Ann Clin Psychiatry* 2011;23:30-39.
- Annual Mental Health Report, The Department of Mental Health, Israel Ministry of Health (in Hebrew) <http://www.old.health.gov.il/download/mental/annual2006/takziv.pdf>. 2006.
- Gil T. Psychiatry and psychotherapy in the managed care era: Present and future in Israel and learning from the American experience. *Harefuah* 2005;144:438-442 (in Hebrew).
- Averbuch E, Kedar N, Horev T. Coping with health inequalities, The Departments of Health Economics and Insurance, Israel Ministry of Health

- (in Hebrew) http://www.old.health.gov.il/download/pages/briut_sofi.pdf. 2010.
27. Ellencweig N, Weizman A, Fischel T. Factors determining satisfaction in psychiatry training in Israel. *Acad Psychiatr* 2009;33:169-173.
 28. Elliott RL, Yudkowsky R, Vogel RL. Quality in psychiatric training - Development of a resident satisfaction questionnaire. *Acad Psychiatr* 2000;24:41-46.
 29. Shih TH, Fan X. Comparing response rates from web and mail surveys: A meta-analysis. *Field Methods* 2008;20:249-271.
 30. Kaplowitz MD, Hadlock TD, Levine R. A comparison of web and mail survey response rates. *Public Opinion Quarterly* 2004;68:94-101.
 31. Couper MP. Web surveys: A review of issues and approaches. *The Public Opinion Quarterly* 2000;64:464-494.
 32. Cook C, Heath F, Thompson RL. A meta-analysis of response rates in web- or internet-based surveys. *Educational and Psychological Measurement* 2000;60:821-836.
 33. Sheehan K. E-mail survey response rates: A review. *J Computer-Mediated Communication* 2001;6:0.

Appendix 1. Residency Institutions

Central vs. Peripheral Institutions

Central medical centers and mental health Centers (in alphabetical order): Abarbanel Mental Health Center, Beer Yaakov Mental Health Center, Brull (Ramat-Chen) Mental Health Center, Geha Mental Health Center, Hadassah Medical Center, Herzog Medical Center, Jerusalem Mental Health Center (Eitanim and Kfar Shaul), Lev Hasharon Mental Health Center, Rambam Medical Center, Schneider Children's Medical Center, Shalvata Mental Health Center, Sheba (Tel-Hashomer) Medical Center, Sourasky (Ichilov) Medical Center, Talbiya Mental Health Center.

Peripheral medical centers and mental health Centers (in alphabetical order): Beer-Sheva Mental Health Center, Ha'Emek Medical Center, Kaplan Medical Center, Mazra Mental Health Center, Sha'ar Menashe V, Ziv Medical Center.

Medical Centers vs. Mental Health Centers

Medical centers (in alphabetical order): Hadassah Medical Center, Ha'Emek Medical Center, Kaplan Medical Center, Rambam Medical Center, Schneider Children's Medical Center, Sheba (Tel-Hashomer) Medical Center, Sourasky (Ichilov) Medical Center, Ziv Medical Center.

Mental health centers (in alphabetical order): Abarbanel Mental Health Center, Beer-Sheva Mental Health Center, Beer Yaakov Mental Health Center, Brull (Ramat-Chen) Mental Health Center, Eitanim Mental Health Center, Geha Mental Health Center, Herzog Medical Center, Jerusalem Mental Health Center (Eitanim and Kfar Shaul), Lev Hasharon Mental Health Center, Mazra Mental Health Center, Sha'ar Menashe Mental Health Center, Shalvata Mental Health Center, Talbiya Mental Health Center.
