

[Experience Sharing Forum]

**Counseling/Psychotherapy With
Chinese Singaporean Clients**

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Singapore is a cosmopolitan state with a mix of Eastern and Westernized values, attitudes, and lifestyles. Like people of other developed countries, Singaporeans do face problems of depression, anxiety disorders, and schizophrenia among other mental illnesses. They, however, have a choice of Western or traditional therapies for managing these illnesses. This article reviews the literature on the efficacy of counseling or psychotherapy with Chinese Singaporeans, the predominant group. Implications for cognitive behavior therapy are discussed, and considerations for conducting therapy with Chinese Singaporean clients are outlined. This resource on the counseling and psychotherapy position in Singapore is offered as a further contribution to this emerging literature.

Theories and practice of counseling and psychotherapy, which have their origins in Euro-American models, have been written and refined specific to disorders and problems. Their use has spread from Europe

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and the United States to other Western and non-Western countries. Among recent endeavors is the focus on counseling and psychotherapy for people other than Westerners, under the heading of cross-cultural/multicultural counseling and psychotherapy, or counseling the culturally different/diverse (e.g., Baruth & Manning, 2003; Feltham & Horton, 2000; Lonner, Dinnel, Forgays, & Hayes, 1999; Paniagua, 2005; Sue & Sue, 2003). Among non-Westerners, Chinese is increasingly a group under study. With reference mainly to Chinese American approaches, the applicability of counseling and psychotherapy has since been progressively studied on Chinese people in countries or cities like Canada, China, New Zealand, Singapore, the United Kingdom, the United States, and Hong Kong (Bond, 1996; Chen & Davenport, 2005; Foo & Kazantzis, in press; Foo & Merrick, 2004; Hong & Domokos-Cheng Ham, 2001; B. O. Lee, 2002; B. O. Lee & Bishop, 2001; S. Y. C. Lee, 2002; Lewthwaite, 1997; Luk et al., 1991; Popadiuk & Arthur, 2004; Walker, Wu, Soothi-O-Soth, & Parr, 1998; Wan, 2001; Wang, 1993; Williams, Foo, & Haarhoff, in press; Williams, Graham, & Foo, 2004; O. N. C. Wong, 1999; Zheng, Zhang, Li, & Zhang, 1997). In these countries, Western approaches to counseling and psychotherapy are recognized to be in the developing stage or have been integrated for use with some form of modifications to suit the socio-cultural environment of the Chinese. Of special mention was that cognitive behavior therapy (CBT) was gaining acceptance among Chinese clients for reasons of suitability and practicality (to be discussed later).

This article reviews the literature surrounding the utility and suitability of counseling and psychotherapy for Chinese Singaporeans. First, the socio-cultural characteristics of Singapore and Singaporeans, particularly Chinese Singaporeans, are briefly reviewed. Then, the mental health status in Singapore and mental health attitudes of Singaporeans and Chinese Singaporeans are discussed. Next, the focus is turned to the development and utilization of Western counseling

and therapy approaches in Singapore and for Chinese Singaporeans, with implications for CBT. Finally, the coexistence of Western and traditional therapies, and modification of Western therapy for Chinese Singaporean clients are discussed with considerations for conducting therapy with Chinese Singaporean clients outlined.

Socio-cultural Characteristics of Singapore and Singaporeans

Singapore, essentially an Asian state with features of collectivism, interdependence, familism, hierarchy, and holistic worldview, is a complex metropolitan state embracing a mix of Eastern and Westernized values, attitudes, and lifestyles. Mainstream Singaporeans are attaining middle-class status (whose concerns are career, education, materialism, progress, and social mobility), and the success symbols for Singaporean youth are education, occupation, and money (Soong, 1997). The degree of Westernization in Singaporeans, however, lies on a continuum depending on personal or group preferences, and environmental influences. A study by D’Rozario and Romano (2000) found that Singaporean students were very different from those of China, Japan, Korea, Taiwan, and other Asian groups due to Westernization and use of English, which was made Singapore’s working language more than two decades ago (Gupta, 1994). Recently, Singapore was selected by New Zealand, among English-speaking countries, to give a balance between Western and Eastern perspectives on complementary and alternative medicine (e.g., traditional Chinese medicine; see Ministry of Health, 2003). On the whole, with acquired affluence and the availability of information on well-being, Singaporeans now pursue better quality of life and health care (Ow, 1998; Tseng et al., 2001).

Socio-cultural Characteristics of Chinese Singaporeans

Chinese Singaporeans make up 76.8% of the 4.48 million population of Singapore (Statistics Singapore, 2006). A number of

Chinese Singaporean virtues that may influence mental health practices are discussed here: academic success, belief in spirits, external locus of control, face, filial piety, first-born, family hierarchy, and moderation (for details, see Chu, 1999; Hong & Domokos-Cheng Ham, 2001; Leslie, 1979; Soong, 1997; Thomas, 1990). High regard for education and academic success prevail in Chinese Singaporeans, and bring about much stress and anxiety in the individual, family, school, and society (Ow, 1998). The belief in spirits and ancestral worship is maintained 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 (Parker, Chen, Kua, Loh, & Jorm, 2000). However, reduced belief in spirituality is emerging among the young, English-educated and highly educated Chinese Singaporeans to practice traditional rituals (Soong, 1997). Chinese normally attribute problems to fate or beyond one's control (external locus of control) (O. N. C. Wong & Piran, 1995).

Face means behaving to uphold one's self-esteem and family's name, and 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 a professional (Kee, 2004). Education is loosening this attitude, and more Chinese Singaporeans are aware of the availability of therapy services for their problems (T. P. Ng, Fones, & Kua, 2003). Filial piety, relating to face, entails loyalty, devotion, respect, and obedience to one's parents, especially the father, and the family's name. Chinese Singaporean youth continue to respect filial piety but are asking more questions, and sometimes challenge its importance (Thomas, 1990). First-born maintains that it be a he. However, with the small family concept, many Chinese Singaporeans have seemingly done away with this desire, as observed. The one- or two-child family may have reduced sibling rivalry, but may have brought on problems of selflessness and coping with societal demands. Family hierarchy, in conjunction with

first-born, sets out that the father is the authority, that parents and elders are to be respected, and that they are always correct. With Westernization, the Chinese Singaporean woman has more or less an equal place in the family, and the only child could be a daughter. Respect for authority is still upheld. Moderation is the tendency to compromise. Chinese Singaporeans, however, may prefer to present disagreement or displeasure in an indirect manner (e.g., unilateral termination of therapy by not turning up again).

Mental Health Status in Singapore and Mental Health Attitudes of Singaporeans

As with developed countries, depression, anxiety disorders and schizophrenia, at prevalence rates of 7.3%, 9.3% and 0.75% respectively, are identified as the major mental disorders in Singapore (C. Yeo, 2004). These disorders are associated with suffering in the patients and emotional burden for the family, affecting productivity and costs of health care. In response, the Singapore government launched a 10-year preventive program “Mind your Mind” in 2001 to increase public awareness of mental health and mental disorders (C. Yeo, 2004). Since the launch of the program, the response from the general public and mental health professionals (MHPs) has been growing. The challenge ahead for mental health promotion in Singapore is to develop dedicated programs relevant to the diverse population and the ever-changing global environment. Additionally, family service centers with integrated counseling 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 health care. However, the perception between MHPs and Singaporeans on mental illnesses and the helpfulness of interventions for them, whether traditional or Western, is diverse. Even among MHPs, each is likely to deem his or her interventions as more helpful than those of others (Parker, Mahendran, Yeo, Loh, & Jorm, 1999).

Although Singaporeans have high needs for mental health care, few consult with MHPs due to stigmatization, reliance on self-help practices, and unfamiliarity with Western therapy approaches, among other reasons. For example, a study by T. P. Ng et al. (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, that 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. In another study on help-seeking among secondary school students in Singapore (R. P. Ang & Yeo, 2004), 84.3% of students were found to be aware of the availability of counseling services in their school, only 13.6% had approached a counselor for help, and 6.7% reported actually having seen a counselor. Additionally, most female students preferred same-sex counselors and most male students preferred opposite-sex counselors, but younger students had indicated a preference for gender- and ethnic-match counselors. In a study by Foo and Merrick (2004), clients cited better understanding, safety, comfort, and same-gender problems as reasons for their preference for a gender- or ethnic-match.

Nonetheless, psychotic illness gets a little more attention with 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. C. Yeo (2004) reported that about 24% of patients with first-episode psychosis sought help from traditional healers at the first onset of symptoms.

Mental Health Attitudes and Behaviors of Chinese Singaporeans

Besides the common mental health disorders, problems peculiar to Chinese Singaporeans include 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 illnesses, many Chinese Singaporeans often attribute their occurrence to supernatural causes (C. Yeo, 2004), and still consider them taboo or mere bad fate. There is also the general apprehension that mental illnesses may be contagious, and that mental health services are associated with psychiatric care and medicine (Hong & Domokos-Cheng Ham, 2001). Furthermore, mental illnesses are relegated second to physical illnesses, which are observable and often accorded immediate attention (Long, 1984; Hong & Domokos-Cheng Ham, 2001). For this reason, mentally ill Chinese Singaporeans may appear with symptoms of so-called somatization — Chinese way of conceptualizing mental health (Lim & Bishop, 2000) — like headache, diffuse bodily ache, insomnia, poor appetite, or a general feeling of physical or mental weakness (Parker, Chen, et al., 2000). Thus, they would present with cognitive anxiety (Lippincott, 1999).

Help-seeking behaviors of Chinese Singaporeans with mental illnesses would include first self-help, then seeking help from relatives, friends or traditional therapies, and lastly, from MHPs (T. P. Ng et al., 2003; Ow, 1998). Self-help strategies might include staying at home, taking tonic drinks, purging medicine, or vitamins, and going on special diets. Should traditional healing practices be sought, they 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, pastors) (Long, 1984; Parker, Mahendran, et al., 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 behaviors. Notably, the more conservative would still use herbal cures or seek the services of traditional healers before, during, or after use of Western medicine, counseling and

psychotherapy. However, 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; T. P. Ng et al., 2003; Ow, 1998), then professional help would be sought.

Development and Utilization of Western Counseling and Therapy Approaches in Singapore, and for Chinese Singaporeans

Counseling is the common term used among formally trained Singapore MHPs like counselors, 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 (A. Ang, 1999), or that “therapy” is preferred. A. Ang (1999, 2001a) contends that professionals trained in medicine and psychodynamic psychotherapy would like to differentiate counseling from psychotherapy. The two terms, however, are used together here for the purposes of the present discussion. Similarly, distinctions of MHPs are not made here; rather, the focus is on general counseling and psychotherapy.

Singaporean researchers have traced the encouraging development of psychology, counseling, and psychotherapy in Singapore (for details, see A. Ang, 2001a; Banerjee, 1999; Chong & Ow, 2003; Elliot, 1999; Long, 1984; Sim, 1999; A. Yeo, 1993). Interestingly, counseling and psychotherapy have gained inroads into the highly regarded biomedical model through public information and provision of allied mental health care services. For instance, MHPs generally agreed that family doctors, psychiatrists, psychologists, counselors, and medication are helpful in treating depression, schizophrenia, and mania (Parker, Lee, et al., 2001; Parker, Mahendran, et al., 1999). Psychology was integrated, among other disciplines, with the biomedical model in the curriculum of

psychiatry in Singapore from 2000 (Kua, 2005). Notably, non-psychiatric MHPs had an average of 2.4 years of psychotherapy training compared with the average of 1.8 years for psychiatrists, who were trained mainly in psychodynamic psychotherapy and CBT (A. Ang, 1999, 2001a). A biopsychosocial model rather than a strict biomedical model for management of the mentally ill was favored by Singapore public psychiatrists (Parker, Chen, et al., 2000). Singaporean doctors were encouraged by A. Ang (1999), a psychiatrist, to learn counseling and psychotherapeutic skills to better their communication skills.

As of 2005, based on estimation of data from various official sources, Singapore has over a thousand MHPs who are locally or overseas trained in the Western models of counseling and psychotherapy, and have adapted them in assessment, diagnosis, and treatment of their clients (Foo & Merrick, 2004; Kee, 2004; Soong, 1997). The various Western models used by Singapore MHPs are behavior, cognitive, family system, and eclectic/integrative models (Foo & Merrick, 2004; Ho, 2000; Soong, 1997). The most commonly used interventions by Singapore MHPs are behavioral management, cognitive therapy, CBT, marital therapy, family therapy, and systemic therapy. English is the medium commonly used in therapy session. Diagnostic references (commonly the DSM IV) and psychometric instruments in use are mainly Western products; some MHPs have made their own behavior checklists for clients. The choice of therapy model or intervention by Singapore MHPs rests on preferences by practitioner or client (Foo & Merrick, 2004; Soong, 1997).

A number of studies have indicated the efficacy of Western therapies with Singaporeans. For example, Devan's (2001) study showed the possible use of moderated psychodynamic group therapy with Singaporean clients. A study by A. Ang (2001a) showed that reassurance was a suitable technique used in psychotherapy regardless

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

A number of specific studies have also indicated the growing acceptance of CBT with Chinese clients. For example, in their years of therapy, Hong and Domokos-Cheng Ham (2001) concluded that the features of CBT — evidence-based, structured, problem-focused, present-focused, action-oriented, short-term psychotherapy (Beck, 1995) — match the expectations of many Asian clients. Chen and Davenport's (2005) study investigated the compatibility of Chinese values, beliefs, characteristics with CBT, and affirmed that with modifications (e.g., making the client the assistant collaborator in therapy, and increasing the time for building rapport with the client before therapy session proper), CBT would appear to be a practical model for working with Chinese American clients in short-term therapy. Williams, Graham, and Foo (2004) proposed a modified 5-part CBT model for working with Chinese clients — factors relating to Chinese characteristics and culture were emphasized, including the translation of these factors into Mandarin. Soong's (1997) study concluded that CBT would fit the fast-paced and task-oriented society of Singapore. Bentelspacher et al.'s (1996) study showed that cognitive-behavioral 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. Huat (1994) had exemplified the use of therapeutic paradox with Chinese clients — in many ways the techniques used in therapeutic paradox like reframing, prescribing, and predicting a relapse are similar to cognitive restructuring and behavior experiment techniques of CBT. Implications for using CBT with Chinese clients in New Zealand and Singapore were also found in the study by Foo and Merrick (2004).

In summary, mental health needs in Singapore exist as in other developed countries (T. P. Ng et al., 2003). As mentioned, the main disorders are depression, anxiety disorders, and schizophrenia. There is also the growing demand for adolescent mental health services (N. B. C. Lee, Fung, Teo, Chan, & Cai, 2003), and the need for more general therapy services, both in training and in clinical settings (Elliot, 1999). Elliot found that there were more psychiatrists than clinical psychologists in Singapore, and Kua (2004) reported that it was not uncommon in a psychiatric clinic to see between 10 and 20 patients in 3 hours. Singapore MHPs generally considered counseling and psychotherapy practices in the developing stage, and found them more acceptable with English-educated Singaporeans (Foo & Merrick, 2004; B. O. Lee & Bishop, 2001). However, the personal meanings of Singaporeans may be different as their English is a combination of English and languages of the various ethnic groups (Elliot, 1999; L. C. J. Wong, Ishiyama, & Wong, 1999).

Given the lack of official publication on ethical issues of MHPs in Singapore, coupled with increasing numbers of formally trained MHPs, growing mental health needs among Singaporeans, and the emergence of various informal counseling and psychotherapy courses, Chong and Ow (2003) recommended the establishment of a registration body in Singapore to ensure ethical delivery of service, and to review their status and practicality. They further recommended carrying out more published research in Singapore which is lacking compared with that of Hong Kong or Taiwan (Sim, 1999). There is also a possibility too of using Singapore as a destination to integrate Western and Eastern therapies. For example, B. O. Lee's (2002) study examined the complementary features of traditional Chinese medicine and folk therapies with Western psychotherapy. He cited case studies of how it was possibly done so. Additionally, Kee (2004) proposed not to focus on how to change Western therapeutic techniques to fit

Singaporean culture, but work with specific cultural features to therapeutic advantage.

Coexistence of Western and Traditional Therapies, and Modification of Western Therapy for Chinese Singaporean Clients

In Singapore, Western medicine coexists with traditional therapies (such as herbal medicine and traditional healers; see B. O. Lee, 2002; Lim & Bishop, 2000). However, most Singaporeans would first consult a doctor of Western medicine for treatment of illness (T. P. Ng et al., 2003). It is suggested that the ubiquity of Western medicine has predisposed their health beliefs (Lim & Bishop, 2000) and relegated traditional therapies to second choice. Western medicine is perceived as appropriate for treating diseases when symptoms are acute, and administered in standardized doses. On the other hand, herbal medicine (like Chinese medicine) is considered when Western medicine is not effective. Herbal medicine is considered suitable for less psychologically distressing or spiritual difficulties, holistic in its emphasis, and individually tailored. That is, a diet change is often recommended as part of herbal treatment (Cobiac, 1998; Lim & Bishop, 2000).

In a study by Parker, Chen, et al. (2000), traditional therapies have been rated unhelpful by Singapore public MHPs for treatment of mental illness. In another study by Foo & Merrick (2004), however, Singapore MHPs agreed that traditional therapies could supplement Western counseling and psychotherapy. Although they did not object to the services of traditional healers, they wanted it conducted outside of therapy sessions. The client would be encouraged to continue therapy and urged to continue taking the medication prescribed. The MHPs, however, would analyze with client the views and outcome of visits to

the traditional healer done at the client's own time, and ensure that they were compatible with Western medicine and therapy. Clients generally had high levels of trust and confidence toward traditional healers, and found them instructive, interactive, directive, with an element of spirituality (Samion, 1999). For example, Chinese Singaporeans who have consulted Chinese medicine doctors found them more caring and concern than Western-trained doctors (Lim & Bishop, 2000).

In conducting therapy, MHPs have noticed two peculiar behaviors of their Chinese Singaporean clients. First of all, most would come into therapy with a personal agenda, as in doing therapy at their time, doing religious counseling, solving their financial or marital problem, providing emotional support for respite care, or dealing with their family first (because of the belief that others are at fault and to be changed first) (Kee, 2004; Soong, 1997). Secondly, Chinese Singaporean clients would frequently ask their MHPs about their experience and personal particulars, as in whether they are married, the number of children they have, and their religious affiliation. MHPs generally consented to give out minimum information about themselves and their experiences to clients. They concurred that self-disclosure was helpful in therapy for rapport building with Chinese Singaporean clients (Foo & Merrick, 2004; McEachern & Kenny, 1999).

Where counseling and psychotherapy are concerned, many researchers concurred that it would be modified for Chinese Singaporean clients (A. Ang, 2001b; R. P. Ang & Yeo, 2004; Devan, 2001; Foo & Merrick, 2004; Ho, 2000; Huat, 1994; Kee, 2004; B. O. Lee, 2002; S. C. Ng, 1999; T. P. Ng et al., 2003; Ow, 1998; Samion, 1999; Sim, 1999; Soong, 1997; A. Yeo, 1993). Modifications for therapy could come in many forms. For example, the inclusion of a psychiatrist in the initial assessment would placate the client of the existence of any organic problem. Utilizing the first couple of sessions

on rapport building would help maintenance of attendance in treatment. Use of Chinese languages (like Mandarin or Cantonese), metaphors, proverbs and folk stories, teachings of Confucianism and Buddhism, reframing of concepts, and therapeutic paradox in therapy sessions would enhance the therapeutic effect. Adoption of a directive or authoritative approach together with eclecticism (most suitable approach to client's problem) would achieve better success as Chinese clients generally respect authority and prefer solution-focused, problem-focused, structured therapy. Reduction of total therapy sessions to few, preferably 6 or less, would entail better therapy success as they prefer quick fixes and hold the attitude of value for money. Inclusion of the client's family in therapy would ensure additional support to clients as Chinese clients are collectivistic. Lastly, "taking of middle ground" (as in "moderation" in Chinese philosophy) would assist in resolving clients' difficult situations. For instance, the parents of the client might want him to study business at the university but he preferred to be a teacher. The solution might be that the client would complete the business degree then went on to do a teaching program. In this way, respect for the parents would be retained while the client could be true to himself.

Notably, a growing percentage of Chinese Singaporeans would prefer a non-directive approach, possibly those in the higher socio-economic status, who are English-educated and more Westernized (Foo & Merrick, 2004; B. O. Lee & Bishop, 2001). For example, in the study of D'Rozario and Romano (2000), Singaporean students, mainly Chinese, had indicated a preference for non-directive counselors. Some of the remarks made by these students on the non-directive counselors were that they are competent, likeable, friendly, well-trained, and very professional and caring. Many students felt positive about the counselors' ability to encourage the client to express his or her feelings, talk through the issue, and begin to problem-solve on his or her own. On

directive counselors, comments were that they sound like my teacher, the counselor is detached, distant, and not friendly enough. The non-directive counselor was perceived as being more expert than the directive counselor. Owing to the paucity of studies on this issue, further research is needed to investigate the finding.

Understandably, doing therapy with Chinese Singaporean clients is not without hitches. For example, the non-directive approach of Western counseling and psychotherapy requiring Chinese Singaporean clients to talk openly, confronting the problem even in the presence of significant others, is radical to many a conservative Singaporean Chinese, who is not verbally expressive and respecting authority. These clients may perceive assertiveness training as aggression (Hong & Domokos-Cheng Ham, 2001; O. N. C. Wong & Piran, 1995; A. Yeo, 1993). Devan's (2001) study found that the psychotherapist was idealized by Chinese Singaporean clients as an expert, a leader and an authority, resulting in dependence on the psychotherapist, which might lead to difficulty in termination.

As a whole, Chinese Singaporean clients' etiology and treatment beliefs about psychological problems are eclectic, deriving from both Western and traditional therapies. Therefore, counseling and psychotherapy approaches combining both Western and Chinese psychotherapies would be likely to be more acceptable, and effective, for them (B. O. Lee & Bishop, 2001). Culbertson (2001) contends that counseling is not foreign to the Chinese — only the process is different. Perhaps, it is appropriate here to wrap up with a summary of the considerations for conducting therapy with Chinese Singaporean clients.

Conclusion

Singapore is a developed state with a mix of Eastern and Westernized values, attitudes, and lifestyles. Singaporeans face mental

health problems of depression, anxiety disorder, schizophrenia and other mental illnesses. They have a choice of Western or traditional therapies for managing their mental illnesses. As discussed, Singapore MHPs have adopted Western counseling and psychotherapy models for use, but have modified them according to Chinese Singaporean cultural values and beliefs. MHPs illustrated that modifications to the Western models could come in the form of using Mandarin or Cantonese in session, applying Chinese metaphors, using mere rapport-building sessions before therapy proper, and using moderation for resolving difficult problems; that CBT might be the choice of therapy model for Chinese Singaporean clients. They were also sensitive to cultural issues, as in making appropriate self-disclosure to gain rapport of Chinese Singaporean clients, discussing religious issues or spirituality, allowing alternative therapies to complement counseling or psychotherapy, working alongside traditional healers, and inclusion of the client's family in session.

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對新加坡華人的心理輔導／治療

新加坡是個融會東、西方價值、態度和生活方式的大都會。新加坡人跟其他已發展國家的人民一樣，都面對憂鬱、焦慮和精神分裂等精神健康問題。然而，新加坡人在應付這些問題時可選擇西方或傳統的治療方法。本文回顧有關心理輔導或治療對新加坡華人（新加坡主要的族群）的效益的文獻。文章亦會討論認知行為治療的意義，以及對新加坡華人進行心理治療時須注意之事項。本文所提出新加坡心理輔導和治療的定位有助相關文獻的發展。