



E-ISSN: 2706-9575  
P-ISSN: 2706-9567  
IJARM 2020; 2(2): 75-84  
Received: 29-04-2020  
Accepted: 15-06-2020

**Dr. Lara Abdullah AlNamlah**  
Family and Community  
Medicine Dept., Prince Sultan  
Military Medical City,  
PSMMC, Riyadh, Saudi  
Arabia

**Mostafa Kofi**  
1) Family and Community  
Medicine Dept., Prince Sultan  
Military Medical City,  
PSMMC, Riyadh, Saudi  
Arabia  
2) Occupational and  
Community Medicine Dept.,  
Faculty of Medicine, Suez  
Canal University, Egypt

**Corresponding Author:**  
**Dr. Lara Abdullah AlNamlah**  
Family and Community  
Medicine Dept., Prince Sultan  
Military Medical City,  
PSMMC, Riyadh, Saudi  
Arabia

## Needs assessment for psychotherapy training among family medicine physicians practicing at PSMMC, Riyadh, Saudi Arabia 2017-2018

Lara Abdullah AlNamlah and Mostafa Kofi

DOI: <https://doi.org/10.22271/27069567.2020.v2.i2a.50>

### Abstract

**Background:** Effective recognition, treatment, and management of mental illnesses in primary health care settings is essential for better patients' outcomes.

**Objectives:** This study aims to identify the current attitudes, knowledge, and practice of family medicine physicians regarding psychotherapy, and to identify needs for further training, if any, on psychotherapy.

**Methods:** In this cross-sectional study, 193 family physicians were selected randomly from 323 family physicians at PSMMC. A final number of 166 were completed after 3 waves; this accounts for 86% response rate. Descriptive statistics and linear regression were used to describe study participants and to identify significant factors.

**Results:** The average knowledge score for psychotherapy was 90.7%. There is no evidence, using regression analysis, of association between knowledge score and the physician's characteristics. The answers in the attitude section revealed a positive attitude from the family physicians towards psychotherapy, along with a willingness to be trained. Majority of PHC physicians indicated they are already practicing psychotherapy at their clinics. There are several prominent barriers for conducting psychotherapy within PHC clinical settings e.g. lack of time, lack of training, and lack of skills.

**Conclusion:** This study shows a prominent level of knowledge regarding psychotherapy, a positive attitude towards it, and an agreed upon need and willingness to attend psychotherapy training among PHC physicians. Additionally, most of the physicians reported practicing psychotherapy at their clinics. However, there are several barriers that need to be tackled to improve the practice.

**Recommendations:** More observational studies are needed to raise awareness and improve practices of psychotherapy in PHC clinics. Professional development workshops are recommended along with focused studies that aim to involve the physicians in attending trainings or courses to accommodate their needs.

**Keywords:** Psychotherapy, Needs Assessment, Family Medicine Physicians

### Introduction

Mental illness can be defined as any behavioral or mental pattern that affects an individual's thoughts, feelings, mood, and behavior <sup>[1]</sup>. Conditions such as depression, schizophrenia, bipolar disorder, obsessive compulsive disorder, panic disorder, post-traumatic stress disorder, personality disorder, eating disorders, and addictive behaviors are associated with mental illnesses <sup>[2, 3]</sup>.

In 2014, the WHO estimated that 25% of the World population suffer from mental illness both in the developed and developing countries <sup>[4]</sup>. It is estimated that 14% of the burden of disease is attributed to mental, neurological, and substance use disorders <sup>[4]</sup>. In Saudi Arabia there is a scarcity of information about the prevalence of mental illnesses among the population <sup>[2]</sup>. Although, studies conducted by Al-Khathami *et al.* 2000 <sup>[5]</sup> and Becker *et al.* 2004 <sup>[6]</sup> both show that one third of primary health care patients have mental illness <sup>[6, 5]</sup>. The estimation of mental illness prevalence among Saudi adolescents ranged between 34.1 and 51% <sup>[7-9]</sup>. These studies were limited with small sample sizes and age group focus.

As to specific mental illnesses such as depression, two studies done in 2014, one in Riyadh and the other in Dammam city. Visitors of three large primary care centers in Riyadh, Saudi Arabia showed that the prevalence of depression (via PHQ-9) was 49.9% <sup>[10]</sup>, while the other study in Dammam done on four PHC showed that the prevalence of moderate to severe depression among adult PHC consumers was about 16% <sup>[11]</sup>.

Studies on the prevalence of other mental disorders is lacking and these individual efforts are not enough to document the size of mental illness and its burden in the country.

Family physicians deal with psychiatric patients in their everyday clinical work [6]. Several studies recognized the need for integrated treatment models in primary care settings to account for mental illnesses [12-14]. Primary care can provide vital information about problem magnitude, and the burden of the illnesses. In family practice settings, treatment and recognition of mental disorders is still not in line with the current medical guidelines and standards [15]. Sub-optimal treatment, under-recognition, and reliance on pharmacotherapy are reported in comparison to current guidelines and psychiatric interviews [16-18]. There are multiple studies on the efficacy of different types of psychotherapy [19-21] and the effectiveness of its use in primary health care [22, 23]. Although, none of these studies have been applied regionally. Better recognition and treatment by family physicians in primary care settings can lead to improvement in the health status to a number of patients [24].

Furthermore, psychotherapy is not part of the official training given to family physicians in their training programs, although it is a skill recommended to be learned in the curriculum [25]. Therefore, based on the information presented above, there is a need for an assessment for psychotherapy training needs among family physicians, and to assess knowledge, attitudes, and current practices aiming to improve mental health care provided to patients attending primary care clinics in PSMMC, Riyadh Saudi Arabia.

Several studies linked primary care and family medicine practice with psychotherapy. However, most of the studies concentrated on using integrated care in primary care i.e. collaboration between family physicians and psychiatrists in treating and diagnosing patients or using certain types of interventions to advance the health status of mental illness patients [14, 26].

Michael Balint [27] in his renowned book 'The Doctor, His Patient and The Illness' emphasized the importance of psychotherapy for the general practitioner and that the medical training at the time was not up to par to the work expected from a general practitioner [27].

A study conducted in 2008 addressed the complexity of capturing mental illnesses in primary care settings [28]. The study identified the considerable differences between primary care and specialists clinics. In primary care settings "problems are presented in undifferentiated forms, with consequent difficulties in distinguishing between distress and disorder, and a complex relationship between psychological, mental and social problems and their temporal variations. Existing psychiatric diagnostic systems, including ICD-10-PHC and DSM-IV-PC, are often difficult to apply in primary care. They do not adequately address comorbidity, the substantial prevalence of sub-threshold disorders or problems with cross-cultural applications. Their focus on diagnosis may be too restrictive, with a need to consider severity and impairment separately." The authors recommended developing a new classification system in primary care that can be easier to implement by the primary care physicians. Additionally, this new system should consider severity, chronicity and disability, feasible for routine data gathering in primary care as well as for training; and promoting better communication between

specialty and primary mental health care [28]. There is a relative lack of studies addressing mental illnesses recognition, treatment, and management in primary care settings [14]. However, this lack of studies may indicate a substantial room of improvement of patients' outcomes in mental illnesses [15].

NICE guideline states that psychotherapy is recommended to be provided by a trained and competent practitioner [29, 30]. Also stating that referral to a psychiatrist is only recommended for those that failed to improve on trials of psychotherapy, medication or a combination of both [30].

Norwegian general practitioners experience on CBT use was explored by Aschim B. *et al.* 2011, recommending that tailored training programs for GP's on CBT will improve its use and make it more frequent. As those that underwent training courses reported positive effect on their consultation skills [31].

A study by Ellen W. *et al.* 2005 reported one third of their physicians used CBT despite having no training and lack of knowledge. It provided CBT training courses for their family physicians and reported that most of them retained and used some of the skills they learned in 6 months' time, despite being met with some obstacles [32].

Physicians in a study by Saadia N. in 2015 [33] addressing psychotherapy in family medicine reported that they practiced psychotherapy regularly, gaining their experience mostly from trial and error as they have not received any training on psychotherapy. The type of coaching they would recommend included under and post graduate and short courses with practical training. They stated that if they were provided with more training they are more likely to conduct psychotherapy more [33].

This study comes as an effort to shed light on the needs for assessment of psychotherapy training for mental illnesses for family doctors in primary care setting in Saudi Arabia. We are optimistic that this study will help in the aim of bettering mental health care in the future of the Kingdom. This study was conducted aiming to identify attitudes, knowledge, and practices of family medicine physicians regarding psychotherapy; and to identify barriers and training needs, if any, on psychotherapy.

## Methods

This section will describe the methodology employed in this study. The design of the study, the sampling method and technique, the investigation tool, the data collection, and the data analysis.

**Study Area:** This study will be conducted in Prince Sultan Military Medical City (PSMMC) and the primary care centers associated with PSMMC which has one of the highest number of family physicians in the whole country of Saudi Arabia (n=323) [34].

## Inclusion criteria

1. Family physicians working at PSMMC

## Exclusion criteria

1. Family physicians on absence
2. Family physicians who refuse to participate

## Study design and sampling method

The study design is cross-sectional. Questionnaires will be completed by the physicians. We assumed the level of knowledge among physicians to be 50% as there are no

pervious studies conducted in the same setting. This assumption will yield the highest number of sample size.

**Using the following formula**

The equation for the sample size calculation as follows:

$$Sample\ Size = \frac{Z^2 pq}{\delta^2} = 385$$

Where,

Z: represents the confidence level, 95% confidence level is the standard choice and for this level, Z = 1.96

p: the expected prevalence of knowledge = 0.50

q=1-p= 1-0.45=0.5

δ: 0.05 is the error tolerated in the estimation.

Sample size=385

We will use the corrected population formula because the population is <20,000.

385/(1+(384/323))=176

Adding 10% for possible non-response and missing data, and the final sample size will add up to 193 family physicians.

**Measurement tool**

The process of the questionnaire adaptation went through several phases as recommended by the guidelines [35].

**Reliability**

The Questionnaire reliability was tested via measuring internal consistency using Cronbach's alpha coefficient. The alpha results values ≥ 0.70 were considered acceptable [36]. The temporal consistency was assessed using test-re-test with two-way mixture intra-class correlation (ICC). The period between the test and re-test was 2-3 weeks with an average 15.1 days [37].

**Validity**

The content validation to ensure the relevancy of the questionnaire was validated using face validation [38]. However, these steps are not sufficient to establish construct validity [39]. External construct validity can be challenging in the absence of gold standard (previously validated questionnaire with similar scope). We used a split-half association to test the correlation between the answers [40]. Pearson's correlation coefficient was applied to test the association between the two halves of the dataset. Questions with coefficients < 0.40 will be considered to lack external validity.

The internal consistency of as measured by the Cronbach's alpha coefficient has been found to be 0.81 for the knowledge subscale, 0.79 for attitude, and 0.84 for practice indicating satisfactory reliability (Table 1). The overall tool reliability was 0.81 with no items showed severe inconsistencies.

**Table 1:** Overall and subscales inner consistency analysis using Cronbach's alpha

Scale	Cronbach's Alpha
Knowledge	0.81
Attitude	0.79
Practice	0.84
All items	0.81

The test-re-test association using ICC are presented in Table 2. The results ranged from 49% to 98%. All the questions showed moderate to high agreement between the test and re-test phase. No question showed statistical inconsistency.

**Questionnaires**

The questionnaire consists of 40 items divided into 4 sets, General Information (7 items), i.e., demographic details of age, gender, nationality, country of graduation, position, years of clinical experience; Knowledge of physicians about psychotherapy (7 items); Attitude of physicians toward psychotherapy in family medicine (13 items). Finally, the practice of psychotherapy by family physicians (13 items). The questionnaire contained different types of questions such as multiple-choice questions, polar questions, and Likert scales.

**Knowledge scoring**

We used a simple scoring technique in our study to assess the physicians' knowledge about psychotherapy. The knowledge section included 6 questions. Each of these questions was given 1 mark. The participant will receive 1 mark for correct answer and 0 for an incorrect answer. The maximum total is 6 answers. The final score is considered by dividing each physician's result over 6 and multiplied by 100%. The overall score then will be the average of the individuals' marks. Question number 7 was not included as it was a stand-alone question.

**The participants**

The version of the questionnaire administered to a sample of family physicians from PHC centers belonging to PSMC in Riyadh, Saudi Arabia. There were no restrictions on the physicians' selection about age or other characteristics. Data collection took place during January 2018 – April 2018. A random sample of 193 physicians was recruited for this study. IRB approval to conduct the study was secured through the PSMC research committee. The consent form was provided before filling in the questionnaire. Confidentiality and anonymity of participants were maintained. Voluntary self-administration of the questionnaire was conducted.

**Sample selection**

The list of family physicians working at PSMC was obtained from the department of Family Medicine. The full list was entered into MS Excel® where each physician was assigned a unique number. The full list included 323 physicians. A random sample of 193 was drawn using a list of random numbers generated using www.random.org website. The final total number of completed questionnaires was 166 with a response rate of 86%.

**Statistical analysis**

Collected questionnaires were entered into a personal computer using MS Excel 2016; data cleaning and verification was then conducted. Afterwards the data was transferred to Statistical package IBM SPSS version 23. We used descriptive statistics to describe study participants and frequency of questionnaire items, and we presented data in frequency tables and diagrams. We also used multiple linear regression to compare independent variables to knowledge score as a dependent variable.

**Ethical consideration**

An ethical approval was obtained from the Research Ethics Committee at PSMMC.

An approval was obtained from the Director of the NGSC clinic of primary care before the pilot study began November 2018.

All pilot study participants were given informed consent along with the questionnaire.

An approval from the head of the PSMMC family medicine department and the in-charge doctor at WHC was obtained, and accordingly the final questionnaire was distributed January, 2018.

All participants were handed an informed consent with their questionnaire.

The questionnaire was anonymous, and participation was voluntary, all the data collected was handled with confidentiality and used for research purposes only.

**Results**

Demographic and background characteristics of the total sample (n = 166) and the sample in each are shown in Table 2. The average age of the participants was 37.6 with almost 11 years average experience. Most of the participant's males 60.2% (100/166). The participants formed mostly from Saudi nationals 57.8% (99/166). The majority of postgraduates obtained their degree nationally 62.0% (103/166).

**Table 2:** Participants' characteristics (n = 166)

Characteristic	Mean ± SD*	Frequency	Percentage
Age (years)	37.6 ± 10.2		
Gender			
Male		100	60.2
Female		66	39.8
Total		166	100.0
Nationality			
Saudi		99	59.6
Non-Saudi		67	40.4
Total		166	100.0
Place of graduation			
Saudi Arabia		96	57.8
Other Arab Country		46	27.7
Non-Arab Country		24	14.5
Total		166	100.0
Place of receiving post-graduate studies, if any?			
National		103	62.0
International		56	33.7
Not applicable		7	4.2
Total		166	100.0
Position			
Consultant		37	22.3
Senior registrar		21	12.7
Registrar		50	30.1
Staff physician		9	5.4
Resident fourth year (R4)		21	12.7
Resident third year (R3)		10	6.0
Resident second year (R2)		13	7.8
Resident first year (R1)		5	3.0
Total		166	100.0
Years of clinical experience	10.9 ± 9.6		

\* SD: Standard Deviation

**Knowledge**

The outcomes of the questions related to knowledge of

psychotherapy among family physicians are presented in Table 3.

**Table 3:** Outcome of knowledge questions (n =166)

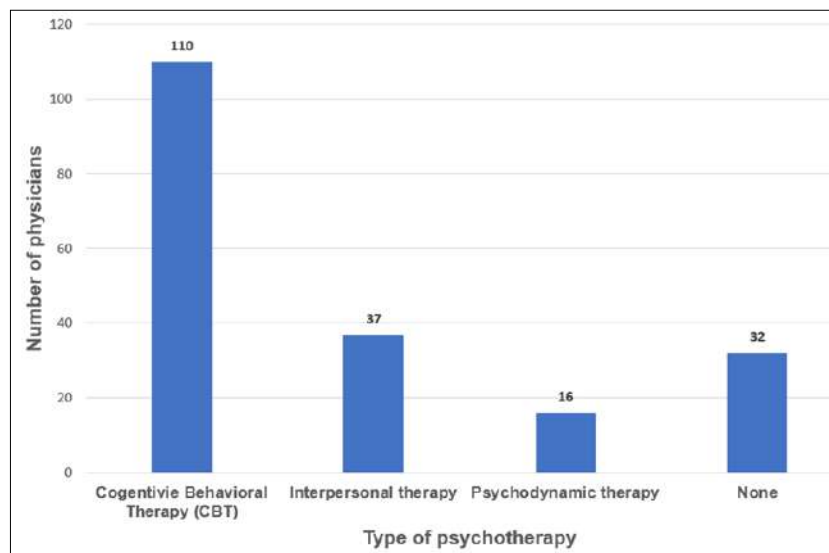
Characteristic	Mean ± SD*	Frequency	Percentage
Average Score (%)	9.3 ± 14.7		
Psychotherapy is a structured psychological intervention			
Incorrect Answers		9	5.4
Correct Answers		157	94.6
Total		166	100.0
Cognitive behavioral therapy (CBT) is an integral part of psychotherapy			
Incorrect Answers		12	7.2
Correct Answers		154	92.8
Total		166	100.0
CBT focuses on thoughts and behaviors			
Incorrect Answers		10	6.0
Correct Answers		156	94.0
Total		166	100.0

Psychotherapy is equal to or superior to psychiatric medication in treating neurosis (e.g., Anxiety, depression, etc.)			
Incorrect Answers		33	19.9
Correct Answers		133	80.1
Total		166	100.0
The combination of psychiatric pharmacotherapy and psychotherapy is the best management for neurosis (e.g., Anxiety, depression, etc.)			
Incorrect Answers		9	5.4
Correct Answers		157	94.6
Total		166	100.0
Psychotherapy is a more beneficial long term in comparison to pharmacotherapy			
Incorrect Answers		56	33.7
Correct Answers		110	66.3
Total		166	100.0

\* SD: Standard Deviation

The participants then were asked about the types of psychotherapy they are familiar with. Their answers are shown in Figure 1. Physicians were given the option to choose more than one type of psychotherapy. Therefore, the

total number of answers can exceed the total sample size. CBT is considered the most familiar type of psychotherapy. Only 32 physicians responded that they are not familiar with any psychotherapy type.



**Fig 1:** Physicians familiarity with different types of psychotherapy

Using regression analysis of knowledge score as a dependent variable, we found that there is no statistically significant physician characteristics affecting it.

Table 4 shows the results of the multivariate linear regression analysis.

**Table 4:** Multivariate linear regression analysis for knowledge score physician's characteristics

Variable	$\beta$	P-value**
Age	0.01	0.966
Gender		
Male	Ref.	
Female	-1.9	0.419
Nationality		
Saudi	Ref.	
Non-Saudi	9.4	0.192
Place of graduation		
Saudi Arabia	Ref.	
Other Arab Country	-16.6	0.058
Non-Arab Country	-9.3	0.223
Place of receiving post-graduate studies, if any?		
National	8.3	0.116
International	9.8	0.091
Not applicable	Ref.	
Position		
Consultant	8.3	0.256
Senior registrar	2.2	0.750
Registrar	4.5	0.512

Staff physician	4.0	0.579
Resident fourth year (R4)	5.9	0.361
Resident third year (R3)	1.5	0.825
Resident second year (R2)	-2.0	0.761
Resident first year (R1)	Ref.	
Years of clinical experience	0.08	0.710

\* SD: Standard Deviation

\*\* P-value is considered statistically significant when it is < 0.05

† CI: Confidence Interval

R<sup>2</sup> = 36.3%

AIC = 1373

**Attitudes**

Attitudes of the physicians towards psychotherapy was measured in the questionnaire by 13 questions. The outcomes of these questions are presented in Table 8. The answers' distribution in Table 8 shows that most of the answers concentrated on the agreement with questions that

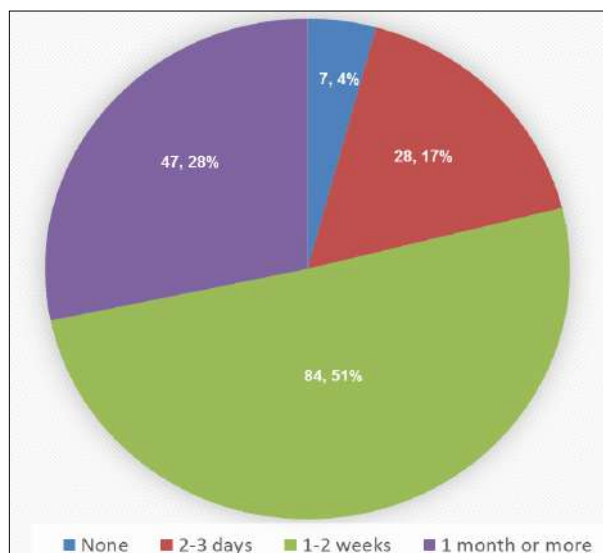
measured the attitude dimension. There is overall agreement whether strongly agreeing or agreeing on items related to physician attitudes towards psychotherapy, with 'need to know more about psychotherapy' and 'agreeing to attend a formal course on psychotherapy' being the most agreed upon statements.

**Table 5:** Physicians' attitude towards psychotherapy (n = 166)

Question	Strongly Disagree (%)	Disagree (%)	Do not know (%)	Agree (%)	Strongly agree (%)
Do you think psychotherapy can be conducted at PHC by family physicians	5 (3.0)	27 (16.3)	24 (14.5)	68 (41.0)	42 (25.3)
Do you think patients with psychiatric problems attending PHC would benefit from psychotherapy	1 (0.6)	9 (5.4)	15 (9.0)	77 (46.4)	64 (38.6)
Do you think psychotherapy is a necessary skill for a family physician to have	3 (1.8)	12 (7.2)	13 (7.8)	74 (44.6)	64 (38.6)
Do you think patients would be more comfortable towards psychotherapy if it is held by a family physician rather than a psychiatrist/psychotherapist	2 (1.2)	29 (17.5)	33 (19.9)	71 (42.8)	31 (18.7)
Do you prefer to do psychotherapy by yourself	4 (2.4)	29 (17.5)	29 (17.5)	69 (41.6)	35 (21.1)
Currently, do you think you can conduct psychotherapy in the clinic if the patient requires it	13 (7.8)	46 (27.7)	32 (19.3)	57 (34.3)	18 (10.8)
Do you think you need to know more about psychotherapy	2 (1.2)	8 (4.8)	8 (4.8)	65 (39.2)	83 (50.0)
Would you agree to attend a formal course on psychotherapy	1 (0.6)	6 (3.6)	11 (6.6)	63 (38.0)	85 (51.2)
If you are properly trained are you willing to run a psychotherapy clinic	6 (3.6)	16 (9.6)	20 (12.0)	73 (44.0)	51 (30.7)
Would you recommend a formal rotation on psychotherapy as part of the psychiatric rotation in the family medicine residency program?	3 (1.8)	8 (4.8)	15 (9.0)	62 (37.3)	78 (47.0)
Would you recommend job training by a psychiatrist/psychotherapist for family physicians?	3 (1.8)	10 (6.0)	18 (10.8)	79 (47.6)	56 (33.7)
Would you recommend a special clinic in PHC dedicated to psychotherapy patients?	2 (1.2)	10 (6.0)	15 (9.0)	74 (44.6)	65 (39.2)

The participants were asked about the length of psychotherapy course they would like to attend with none being an option. The majority 51% are willing to attend a course 1-2 weeks in length, 28% preferred a course for one

month or longer, 17% said they are interested in attending a 2-3 day course, while 4% preferred not to attend a course at all. The results of this question are visualized in Figure 2.



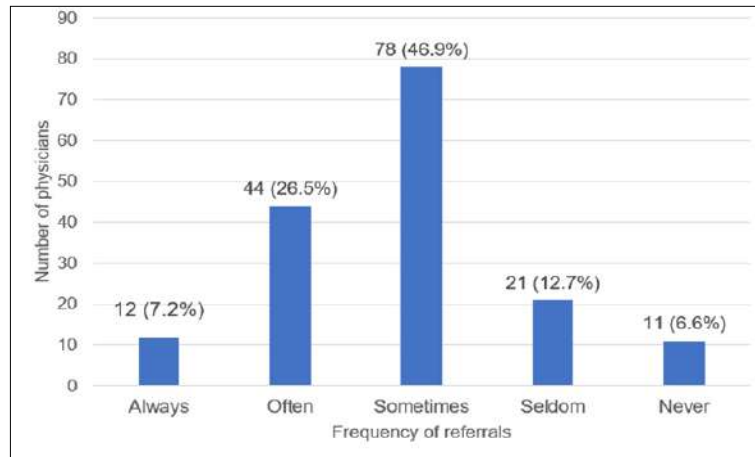
**Fig 2:** Length of psychotherapy training course physicians are interested to attend

**Practice**

This section concerns the analysis of the questions related to the physician's practice of psychotherapy.

Figure 3 shows the frequency of referral of patients for psychotherapy when indicated. Most of the physicians

answered that they sometimes refer patients that indicate the need for psychotherapy 47.0% (78/166). Physicians who often refer patients for psychotherapy formed 26.5% (44/166). Only 6.6% (11/166) answered that they never refer patients for psychotherapy.



**Fig 3:** Frequency of referring patients for psychotherapy when indicated

When asked about the practice of psychotherapy (Table 6), 64.5% (107/166) of the physicians answered that they had practiced psychotherapy at some point at their clinics. The most used type of psychotherapy is CBT 66.4% (71/107).

The most mental illnesses physicians used psychotherapy for in their clinics were depression and anxiety both at 88.8% (95/107).

**Table 6:** Physicians who practice psychotherapy at their clinics

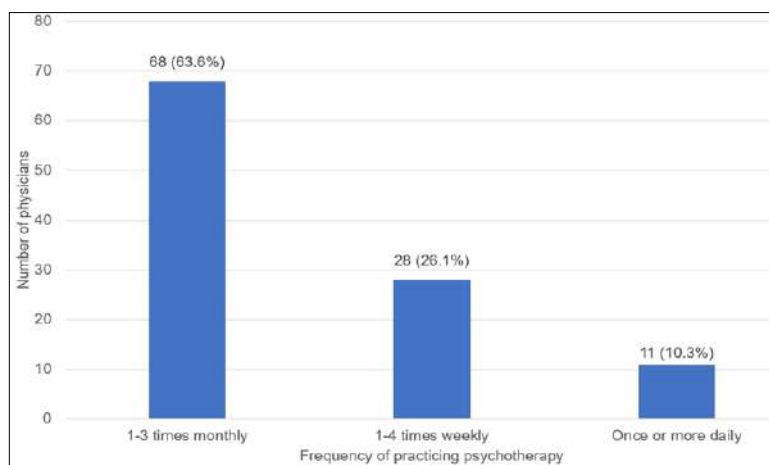
Statement	Answered Yes	Percentage
Have you ever practiced psychotherapy in your clinical practice?	107	64.5%
What type of psychotherapy do you practice		
CBT*	71	66.4%
Psychodynamic therapy	6	5.6%
Interpersonal therapy	40	37.4%
Which disorders do you use psychotherapy for, in your clinical practice?		
Depression	95	88.8%
Anxiety	95	88.8%
Obsessive Compulsive Disorder (OCD)	37	34.6%
Panic disorder	57	53.3%
PTSD**	41	38.3%

\* CBT: Cognitive Behavioral Therapy

\*\* PTSD: Post Traumatic Stress Disorder

Most of the physicians answered that they practice psychotherapy at their clinics (Figure 4). Those who practice psychotherapy 1-3 times monthly formed 63.6%

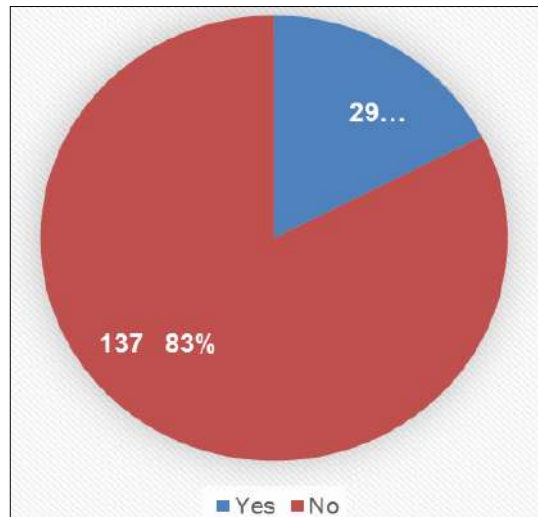
(68/107). While those practicing psychotherapy 1-4 times weekly were 26.1% (28/107) and 10.3% (11/107) practiced daily.



**Fig 4:** Frequency of practicing psychotherapy at PHC clinics

In Figure 5, the physicians were asked if they have ever attended a psychotherapy course. Most of the respondents

reported that they have never attended such course 83.0% (137/166).



**Fig 5:** Ever attended a course on psychotherapy

The barriers to practicing psychotherapy at clinics are shown in Table 7. Most of the statements were agreed upon by the physicians (76.1% - 93.4%). The only statement that

received below 50% agreement is the statement about patient’s resistance towards psychotherapy (40.3%)

**Table 7:** Barriers to practicing psychotherapy at PHC clinics

Question	Strongly Disagree (%)	Disagree (%)	Do not know (%)	Agree (%)	Strongly Agree (%)
Patient’s resistance towards psychotherapy	10 (6.0)	52 (31.3)	37 (22.3)	55 (33.1)	12 (7.2)
Lack of skills, ability or training to perform psychotherapy	2 (1.2)	8 (4.8)	9 (5.4)	86 (51.8)	61 (36.7)
Not enough practice of psychotherapy	1 (0.6)	7 (4.2)	12 (7.2)	86 (51.8)	60 (36.1)
Not enough time for psychotherapy in the clinic	1 (0.6)	7 (4.2)	3 (1.8)	69 (41.6)	86 (51.8)
Too many interruptions to perform psychotherapy	3 (1.8)	12 (7.2)	24 (14.5)	72 (43.4)	55 (33.1)
No proper clinical setting to carry out psychotherapy	2 (1.2)	9 (5.4)	16 (9.6)	70 (42.2)	69 (41.6)

**Discussion**

This study aimed to assess knowledge, attitude, and practice of family medicine physicians regarding psychotherapy, along with their perceived barriers that may affect psychotherapy practice.

In this study, the average knowledge score about psychotherapy was 90.7% among family medicine physicians. The results show a high knowledge level about certain aspects of psychotherapy. The result is higher than a study conducted on 215 family physicians in the US where the level of knowledge was (51%) [41].

The results indicated that several beliefs of family physicians were contrary to evidence obtained from epidemiologic studies.[41] Gallo in 1999 concluded that in their self-assessment about ability to evaluate depression only 53% feel confident, while in 2002 he also concluded that a high number of physicians reported lack of knowledge about psychotherapy or depression [41, 42].

Several studies also showed that family physicians have more tendency to use pharmacotherapy over psychotherapy [43, 44]. One study

attributed such tendency to the impracticality of psychotherapy in primary care settings [44]. This barrier was considered by our sampled physicians as a constraint for performing psychotherapy in primary care and family medicine clinics. In our study 93.4% of the physicians considered lack of time is the most prominent barrier for conducting psychotherapy.

The second dimension of this study concerned the attitude of family medicine physicians towards psychotherapy. The sampled physicians responded favorably to the statements about psychotherapy in the PHC setting. All of the statement about the psychotherapy was agreed with by our respondents. The statement that received less than 50% agreement (45.1%) was the one regarding their ability to conducted psychotherapy in the clinics. This level of agreement is still lower than what has been reported [43-45]. However, the physicians showed a high willingness to attend psychotherapy training. This finding is comparable with their view as lack of training is a major barrier to practicing psychotherapy in clinics.

However, in the issue of training, in a focused group study by van Rijswijk *et al.* 2009 about the barriers of recognizing and treating certain mental illnesses the authors reported “Intervention studies to improve the standard of care- focusing on education, dissemination, and implementation of guidelines and use of screening instruments- are not particularly encouraging especially regarding patient outcome. Next, to benefits of the programs, we assumed that such interventions insufficiently match with the problems experienced by family physicians (FPs)” [15] van Rijswijk and colleagues 2009 suggested that open discussion with physicians can lead to a better understanding about their needs to conduct more efficient counseling and better patients outcomes [15]. Such approach will ensure more input from the physicians in the training process, and will allow



the adaptation of a model that suits their need. This is particularly important as cross-cultural adaptation of guidelines and training programs seems to be inefficient approach<sup>[46]</sup>.

In the third dimension that concerned the physician's practice, most physicians reported conducting psychotherapy at some stage (64.5%). However, 83% reported that they have never attended psychotherapy training. Practicing psychotherapy without proper training can lead to underrecognition<sup>[47]</sup>. While providing the proper tools and training can significantly improve the patients' outcomes<sup>[16]</sup>. In a country like Saudi Arabia, the depression levels among the population are very alarming, especially among women. The ministry of health reported at least 20% of the women in the country to suffer from depression, with studies from primary care clinics estimate the prevalence to be around 22%<sup>[10]</sup>. Al-Qadhi and colleagues 2014 reported that this prevalence rate is underestimated, 40%-50% of the mental illnesses are not recognized by primary care physicians<sup>[10]</sup>. This claim is supported by a systematic review conducted to estimate the prevalence of depression in Saudi Arabia. The study approximated the prevalence of depression to be 46%<sup>[48]</sup>. Saadia H. in 2015 suggested that participants felt that if they get more training, they are more likely to do more psychotherapy<sup>[33]</sup>.

The barriers to conducting psychotherapy were assessed by our study. Several barriers were recognized by the sampled physicians. The study by van Rijswijk suggested that patient's resistance is the most notable barrier by a focused group discussion with 68 family physicians<sup>[15]</sup>. This barrier was least considered by our physicians. It's been reported by RK McHugh *et al.* 2013 that patients seem to be more accepting these days to the idea of treating mental illnesses with psychotherapy<sup>[49]</sup>.

### Limitations

The study is based on a self-administrated questionnaire. This means that it was not based on observations of real-time practice or patient records. All our respondents are sampled from one major medical city which may not be representative to all family physicians.

### Strengths

This work is pioneer in addressing a topic that is less researched in PHC in Saudi Arabia. Additionally, findings are important in recommending how to solve the problem and barriers against doing psychotherapy at PHC by family medicine physicians.

### Conclusion

There is high level of knowledge among physicians, positive attitude, and practice of psychotherapy. However, the under recognition of mental illnesses is noted in several studies in PHC settings which identified in our study by the physicians in the lack of training as a barrier. There is a need for more involvement of the physicians in attending training and courses to meet their needs.

### Recommendations

1. To conduct more studies that assess actual psychotherapy practices in PHC clinics.
2. To conduct studies with family physicians to describe barriers they face in their clinics regarding practicing psychotherapy, and ways to manage it.

3. To set up training workshops, along with professional development courses to accommodate the needs of PHC family medicine physicians regarding practice of psychotherapy.

### References

1. Duckworth K. Mental Illness: What you need to Know. Arlington VA: National Alliance on Mental Illness, 2013.
2. Almutairi AF. Mental illness in Saudi Arabia: an overview. *Psychology Research and Behavior Management*. 2015; 8:47-9.
3. Doran C. Prescribing Mental Health Medication: The Practitioner's Guide. New York, NY: Routledge, 2005.
4. World Health Organization. WHO Mental Health Gap Action Programme (mhGAP). Geneva, 2017.
5. Al-Khathami AD, Ogebeide DO. Prevalence of mental illness among Saudi adult primary-care patients in Central Saudi Arabia. *Saudi medical journal*. 2002; 23(6):721-4.
6. Becker SM. Detection of somatization and depression in primary care in Saudi Arabia. *Social psychiatry and psychiatric epidemiology*. 2004; 39(12):962-6.
7. Al-Sughayr AM, Ferwana MS. Prevalence of mental disorders among high school students in National Guard Housing, Riyadh, Saudi Arabia. *Journal of Family and Community Medicine*. 2012; 19(1):47.
8. Al-Gelban KS. Depression, anxiety and stress among Saudi adolescent school boys. *The journal of the Royal Society for the Promotion of Health*. 2007; 127(1):33-7.
9. Al-Modayfer O, Alatiq Y. A Pilot Study on the Prevalence of Psychiatric Disorders among Saudi Children and Adolescents: a Sample from a Selected Community in Riyadh City. Walid Sarhan Elie Karam-Lebanon the Honorary editors Ahmad Okasha-Egypt Adnan Takriti-Jordan the Associate Editors John Fayyad-Lebanon. 2015; 26(2):184-92.
10. Al-Qadhi W, UR Rahman S, Ferwana MS, Abdulmajeed IA. Adult depression screening in Saudi primary care: prevalence, instrument and cost. *BMC psychiatry*. 2014; 14(1):190.
11. Aldabal BK, Koura MR, Alsowielem LS. Magnitude of depression problem among primary care consumers in Saudi Arabia. *International Journal of Medical Science and Public Health*. 2015; 4(2):205-10.
12. E Shaw S, Bailey J. Discourse analysis: what is it and why is it relevant to family practice? *Family Practice*. 2009; 26(5):413-9.
13. Kessler D, Lewis G, Kaur S, Wiles N, King M, Weich S *et al.* Therapist-delivered internet psychotherapy for depression in primary care: a randomised controlled trial. *The Lancet*. 2009; 374(9690):628-34.
14. Roy-Byrne P, Craske MG, Sullivan G, Rose RD, Edlund MJ, Lang AJ *et al.* Delivery of evidence-based treatment for multiple anxiety disorders in primary care: a randomized controlled trial. *Jama*. 2010; 303(19):1921-8.
15. Van Rijswijk E, Van Hout H, Van de Lisdonk E, Zitman F, Van Weel C. Barriers in recognising, diagnosing and managing depressive and anxiety disorders as experienced by Family Physicians; a focus group study. *BMC Family Practice*. 2009; 10:52.
16. Goldberg D, Privett M, Ustun B, Simon G, Linden M. The effects of detection and treatment on the outcome

- of major depression in primary care: a naturalistic study in 15 cities. *The British journal of general practice: the journal of the Royal College of General Practitioners*. 1998; 48(437):1840-4.
17. Kerr MP. Antidepressant prescribing: a comparison between general practitioners and psychiatrists. *The British journal of general practice: the journal of the Royal College of General Practitioners*. 1994; 44(383):275-6.
  18. McManus P, Mant A, Mitchell P, Britt H, Dudley J. Use of antidepressants by general practitioners and psychiatrists in Australia. *The Australian and New Zealand journal of psychiatry*. 2003; 37(2):184-9.
  19. Hofmann SG, Smits JA. Cognitive-behavioral therapy for adult anxiety disorders: a meta-analysis of randomized placebo-controlled trials. *The Journal of clinical psychiatry*. 2008; 69(4):621.
  20. Butler AC, Chapman JE, Forman EM, Beck AT. The empirical status of cognitive-behavioral therapy: a review of meta-analyses. *Clinical psychology review*. 2006; 26(1):17-31.
  21. Cusack K, Jonas DE, Forneris CA, Wines C, Sonis J, Middleton JC *et al*. Psychological treatments for adults with posttraumatic stress disorder: A systematic review and meta-analysis. *Clinical Psychology Review*. 2016; 43:128-41.
  22. Twomey C, O'Reilly G, Byrne M. Effectiveness of cognitive behavioural therapy for anxiety and depression in primary care: a meta-analysis. *Family practice*. 2015; 32(1):3-15.
  23. Linde K, Sigterman K, Kriston L, R ucker G, Jamil S, Meissner K, Schneider A. Effectiveness of psychological treatments for depressive disorders in primary care: systematic review and meta-analysis. *The Annals of Family Medicine*. 2015; 13(1):56-68.
  24. Ormel J, Tiemens B. Recognition and treatment of mental illness in primary care. Towards a better understanding of a multifaceted problem. *General hospital psychiatry*. 1995; 17(3):160-4.
  25. SCHS. Saudi Board Family Medicine – Curriculum, 2016, 85-86.
  26. Patel V, Weiss HA, Chowdhary N, Naik S, Pednekar S, Chatterjee S *et al*. Effectiveness of an intervention led by lay health counsellors for depressive and anxiety disorders in primary care in Goa, India (MANAS): a cluster randomised controlled trial. *The Lancet*. 2010; 376(9758):2086-95.
  27. Balint M. *The doctor, his patient and the illness*, 1957.
  28. Gask L, Klinkman M, Fortes S, Dowrick C. Capturing complexity: The case for a new classification system for mental disorders in primary care. *European Psychiatry*. 2008; 23(7):469-76.
  29. Excellence. NifHaC. Generalized anxiety disorder and panic disorder in adults: Management. London: NICE, 2011.
  30. Excellence. NifHaC. Depression in adults: recognition and management. London: NICE; October 2009, updated April, 2016.
  31. Aschim B, Lundevall S, Martinsen EW, Frich JC. General practitioners' experiences using cognitive behavioural therapy in general practice: A qualitative study. *Scandinavian journal of primary health care*. 2011; 29(3):176-80.
  32. Wiebe E, Greiver M. Using cognitive behavioural therapy in practice: qualitative study of family physicians' experiences. *Canadian Family Physician*. 2005; 51(7):992-3.
  33. Hameed SN. *Psychotherapy in Family Medicine*. 2015.
  34. Statistical book in: indicators Msa, editor. 10 ed. Saudi Arabia: Ministry of Health, 1436, 86-96.
  35. Beaton DE, Bombardier C, Guillemin F, Ferraz MB. Guidelines for the process of cross-cultural adaptation of self-report measures. *Spine*. 2000; 25(24):3186-91.
  36. Tavakol M, Dennick R. Making sense of Cronbach's alpha. *International journal of medical education*. 2011; 2:53.
  37. Kirshner B, Guyatt G. A methodological framework for assessing health indices. *Journal of chronic diseases*. 1985; 38(1):27-36.
  38. Blum-Fowler C, Peterson C, McChurch JF, Le Clech Y, Humphreys BK. Translation and validation of the German version of the Bournemouth questionnaire for low back pain. *Chiropractic & Manual Therapies*. 2013; 21(1):32.
  39. Wild D, Grove A, Martin M, Eremenco S, McElroy S, Verjee-Lorenz A *et al*. Principles of Good Practice for the Translation and Cultural Adaptation Process for Patient-Reported Outcomes (PRO) Measures: report of the ISPOR Task Force for Translation and Cultural Adaptation. *Value in health: the journal of the International Society for Pharmacoeconomics and Outcomes Research*. 2005; 8(2):94-104.
  40. Bolton P. Cross-cultural validity and reliability testing of a standard psychiatric assessment instrument without a gold standard. *The Journal of nervous and mental disease*. 2001; 189(4):238-42.
  41. Gallo JJ, Ryan SD, Ford DE. Attitudes, knowledge, and behavior of family physicians regarding depression in late life. *Archives of family medicine*. 1999; 8(3):249.
  42. Gallo JJ, Meredith LS, Gonzales J, Cooper LA, Nutting P, Ford DE *et al*. Quality Improvement for Depression Consortium. Do family physicians and internists differ in knowledge, attitudes, and self-reported approaches for depression? *The International Journal of Psychiatry in Medicine*. 2002; 32(1):1-20.
  43. Elder A. Psychotherapy in primary care. *Psychiatry*. 2005; 4(5):24-8.
  44. Mohr DC, Hart SL, Howard I, Julian L, Vella L, Catledge C *et al*. Barriers to psychotherapy among depressed and nondepressed primary care patients. *Annals of Behavioral Medicine*. 2006; 32(3):254-8.
  45. Landreville P, Gervais P. Psychotherapy for depression in older adults with a disability: where do we go from here? *Aging & Mental Health*. 1997; 1(3):197-208.
  46. Hodges B, Inch C, Silver I. Improving the psychiatric knowledge, skills, and attitudes of primary care physicians, 1950-2000: a review. *American Journal of Psychiatry*. 2001; 158(10):1579-86.
  47. Carkhuff R. *Toward Effective Counseling and Psychotherapy*. New York: Routledge, 2007.
  48. Alibrahim OA, Al-Sadat N, Elawad NAM. Gender and risk of depression in Saudi Arabia, a systematic review and meta-analysis. *Journal of Public Health in Africa*. 2010; 1(1):e7.
  49. McHugh RK, Whitton SW, Peckham AD, Welge JA, Otto MW. Patient preference for psychological vs pharmacologic treatment of psychiatric disorders: a meta-analytic review. *The Journal of clinical psychiatry*. 2013; 74(6):595-602.