PSYCHIATRIC SYMPTOMATOLOGY, ATTACHMENT STYLE, AND BURNOUT AMONG MENTAL HEALTH PROFESSIONALS IN TURKEY

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Türkiye'deki Ruh Sağlığı Çalışanlarının Psikiyatrik Semptom Düzeyleri, Bağlanma Stilleri ve Tükenmişlik Seviyeleri

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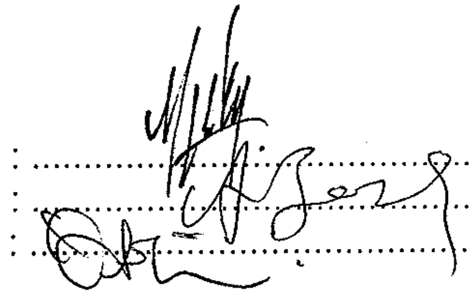

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Abstract

The main purpose of this study was to investigate mental health profiles, attachment styles, and burnout among mental health professionals in Turkey. A sample of 245 professionals including psychologists, psychiatrists, counselors, social workers and other mental health professionals filled out the questionnaire. The public link of the survey, together with an introductory statement about the content and purpose of the study, was sent to major email groups joined by mental health professionals. The survey was also converted into a Word format, printed and distributed to major hospitals and counseling and psychotherapy clinics in Istanbul. The findings showed that mental health professionals in Turkey are psychologically healthier than normal comparisons. They also displayed a higher frequency of secure attachment together with a lower frequency of insecure attachment compared to the general population. Contrary to expectations, burnout was not experienced by the sample. Attachment style was significantly related to both psychiatric symptomatology and burnout. In addition, significant correlations between mental health and burnout scores were also obtained. The study further investigated factors that predict psychiatric symptomatology and burnout among mental health professionals in Turkey. Lastly, limitations of this study and implications for further research were discussed.

Özet

Bu çalışmanın temel amacı, Türkiye'deki ruh sağlığı çalışanlarının ruh sağlığı profillerini, bağlanma stillerini ve tükenmişlik düzeylerini incelemektir. Araştırma anketini içlerinde psikolog, psikiyatrist, psikolojik danışman, sosyal hizmet uzmanı ve diğer ruh sağlığı çalışanlarından oluşan toplam 245 katılımcı doldurdu.. Anketin linki, çalışmanın amacını içeren bir ön yazıyla birlikte Türkiye'deki ruh sağlığı çalışanlarının üye olduğu e-posta gruplarına gönderildi. Anket aynı zamanda Word formatına da çevrilerek İstanbul'daki başlıca hastane, klinik ve psikoterapi merkezlerine gönderildi. Araştırmanın sonuçları Türkiye'deki ruh sağlığı çalışanlarının psikolojik olarak normal gruba göre daha sağlıklı olduğunu göstermiştir. Ruh sağlığı çalışanlarındaki güvenli bağlanma oranı da normal popülasyona göre daha yüksek bulunmuştur. Beklentilerin aksine, çalışma örnekleminde tükenmişlik seviyesi düşük çıkmıştır. Bağlanma stili ile psikiyatrik semptom düzeyi ve tükenmişlik arasında istatistiksel olarak anlamlı bir ilişki bulunmuştur. Buna ek olarak ruh sağlığı ve tükenmişlik arasında da anlamlı bir ilişki bulunmuştur. Bu çalışmada ayrıca psikiyatrik semptomatoloji ve tükenmişliği yordayan faktörler de incelenmiştir. Son olarak araştırmanın sınırlılıkları ve gelecek araştırmalara dair öneriler belirtilmiştir.

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CHAPTER 1. INTRODUCTION

There is a widely held belief that mental health professionals work under a vast amount of stress. “Isn’t it depressing to listen to all kinds of problems every day?” is only one example of the questions that clinicians are exposed to during their everyday life. Indeed, Wood et al. (1985) state that apart from environmental stressors and personal difficulties, psychotherapists have to deal with additional stressors unique to their profession. These include problems related to their professional identity in their daily lives, the absence of reciprocity in relationships with clients, slow and erratic nature of the therapeutic process, and personal issues that are raised as a result of their work with patients. As English (1976), in his discussion of the emotional distress faced by psychotherapists, nicely puts: “If one wayward child can impair the morale of a whole family, it therefore stands to reason that ten disturbed patients are going to take their toll on the therapist” (p. 197).

Although most people are aware of the fact that mental health workers are dealing with a large amount of stress, they also believe that mental health professionals are psychologically healthier and somewhat immune to the problems their patients are suffering from. The scientific evidence, however, indicates quite the opposite. In fact, mental health professionals are experiencing impairment due to several psychological problems including depression, anxiety, relationship problems, burnout, and even substance abuse (eg., Deutsch, 1984; Pope & Tabachnick, 1994;

Thoreson, Miller, & Krauskopf, 1989; Thoreson, Natahan, Skorina, & Kilburg, 1983).

Compared with research on normal population in terms of their psychological difficulties, research on psychological difficulties of mental health professionals is rather limited. This is especially the case in Turkey. Therefore, the aim of this thesis is to investigate psychiatric symptomatology, burnout rates, and attachment styles of mental health workers in Turkey.

1.1. Mental Health Profiles of Mental Health Professionals

1.1.1. Depression

Depression is a mood disorder which includes a wide range of emotional, physiological and behavioral, and cognitive symptoms. Examples of these symptoms include persistent feelings of unhappiness, depressed mood, disturbances in sleep and appetite, lack of energy, and feelings of hopelessness (APA, 2000). The prevalence of depression has been estimated as 17 % within American population (Kessler et al., 1994). A study of prevalence of depression in Turkey found that prevalence of depressive symptoms is 20 % whereas the prevalence of clinical depression is around 10 % in Turkey (Küey & Güleç, 1989).

Thoreson, Miller, and Krauskopf (1989) investigated sources of stress among PhD-level clinical and counseling psychologists. Their findings revealed their sample was overall psychologically healthy. Among those reported themselves as distressed, depression was the most frequently mentioned source of distress. Similarly, Deacon, Kirkpatrick, Wetchler, and

Niedner (1999) found that depression was among the most commonly stated problems by marriage and family psychotherapists. Swearingen (1990) and Wood et al. (1985) estimated the prevalence of depression in psychiatrists as 60% to 90%, suggesting that in several cases, symptoms of depression are unnoticeable. A study carried out by Pope and Tabachnick (1994) revealed that among psychologists who are currently receiving psychotherapy, 61 % reported that clinical depression was their main reason to seek psychotherapy.

In a study with licensed psychologists, Wood, Klein, Cross, Lammers and Elliott (1985) found that 32.3% of their sample reported having been affected by depression. In addition, more than 60 % reported knowing colleagues or co-workers who are affected by depression.

Moldovan (2006) compared depression levels of psychotherapists and normal population in a Romanian sample. His results indicated no significant differences between psychotherapists and participants from the general population in terms of their depressive symptomatology.

Deutsch (1985) investigated psychotherapists' personal problems and whether they seek treatment for these problems. In his sample, 57% stated having suffered from depression. In terms of treatment, 27% had been in therapy and 11% had received medical treatment for their depressive symptoms. Deutsch also found within group differences related to gender, education-level, and place of employment. In particular, women had received more medical and psychotherapeutic treatment than men for their depression. In addition, master's level therapists were more likely to report

having been depressed and to seek treatment for their depression than doctoral-level therapists. Moreover, depression was more prevalent within self-employed therapists than therapists working in some kind of institution.

Overall, research shows that the prevalence of depressive symptoms in mental health professionals ranges between 32.3 to 57%. Kessler et al. (1994) estimated the lifetime prevalence of an acute depressive episode in the United States as 17 %. Similarly, Küey and Güleç (1989) have found that the prevalence of depressive symptomatology is approximately 20 % and that of clinical depression is 10% in Turkey. Taken as a whole, these findings indicate that depression is far more common in mental health professionals than in normal population.

1.1.2. Anxiety

Anxiety is a physiological and psychological condition characterized by emotional, cognitive, somatic and behavioral elements (Nolen-Hoeksema, 2004). Anxiety is a major component in most psychological disorders including depression, panic disorder, obsessive compulsive disorder, phobias, etc. In addition to common sources of stress, Kilburg, Kaslow, & VandenBos (1988) claim that mental health workers face additional stressors resulting from their work with mild to severe psychological problems of their patients and are therefore more at risk in terms of anxiety symptoms.

Moldovan compared psychotherapist and general population in terms of several psychiatric symptoms including state and trait anxiety. His results revealed no significant difference between the two groups in terms of both

state and trait anxiety. In a similar study, Bore, Brown, Gallagher and Powis (2008) investigated psychology and medicine students regarding their psychiatric symptoms. They found that both medical and psychology students had significantly higher scores on obsessive-compulsive symptoms compared to adult nonpatient norms. In fact, OCD symptoms of 1st year medicine and psychology students were even higher that psychiatry inpatient norms. The authors concluded that these findings might have significant implications in terms of understanding the unique stressors faced by mental health professionals and need further exploration and replication.

Pope and Tabachnick (1994) studied psychologist which are or had been under personal psychotherapy. They found that anxiety is one of the major problems that psychologist focused in their personal therapy. It seems that anxiety, with its several forms, is a common problem faced by mental health professionals.

Bozdoğan (2007) compared nurses working in psychiatry clinics to those working in nonpsychiatric departments in Turkey in terms of their psychiatric symptomatology by using Brief Symptom Inventory. She found no significant between group differences in terms of symptoms including depression, anxiety, obsessive-compulsivity, and psychoticism.

1.1.3. Substance and Alcohol Abuse

A person is given the diagnosis of substance abuse when his/her repeated use of the substance results in major harmful consequences. DSM-IV recognizes four types of harmful consequences that characterize substance abuse. First, the person has difficulty in performing major

requirements at work, school, or home as a result of using the substance. Second, the person continually uses the substance even when it is physically dangerous to do so. Third, the person frequently has legal problems due to substance use. Fourth, the person continues using the substance even though he/she continually has social or legal problems due to substance use (APA, 2000). A survey by U.S. Substance Abuse and Mental Health Services Administration (2002) revealed that more than one-third of the U.S. population have used an illegal substance at some point in their lives, and approximately 11 percent have did it during the previous year.

Wood et al. (1985) investigated factors that lead to professional impairment among licensed psychologists. They found that 4.2 % of the sample has experienced problems with their work due to substance or alcohol use. Moreover, approximately 40% have known colleagues whose work is affected by excessive use of alcohol or drugs.

A study carried out by Thoreson et al. (1989) indicated that the prevalence of problem drinking among psychologists ranges between 6 % and 9 %. Based on this finding, the authors argue that approximately 6 000 out of 100 000 psychologists in the United States are suffering from alcoholism. Their study also revealed that depression, relationship problems, and anxiety are more common among psychologists having problems with alcohol use compared to those who were not engaging in problem drinking behavior.

Emerson and Markos (1996) argue that patients of counselors who have alcohol or drug use problems rarely recognize the impairment because

counselors usually organize their practice around their alcohol or drug use routine. These professionals also provide their privacy through working in private practice and minimizing their contact with other professionals. Therefore the authors argue that a large number of professionals having problems with drug or alcohol use remain undetected.

1.1.4. Relationship Problems

In a study with psychologist in clinical practice, Sherman and Thelen (1998) found that relationship problems lead to greatest amount of distress and impairment among psychologists. A similar study by Deacon et al. (1999) also revealed that marriage and relationship problems are among the most common problems experienced by marriage and family therapists.

Guy, Poelstra and Stark (1989) investigating sources of distress and professional impairment in psychotherapists. He found that 20.4 % of the sample indicated experiencing distress due to marital problems within the past three years. Similarly, Norcross and Prochaska (1986) studied sources of distress among psychotherapists and revealed that 28.1% have experienced significant amount of distress as a result of relationship problems.

Pope and Tabachnick (1994) surveyed psychotherapist in terms of their personal problems, with an emphasis on those directing them towards getting personal psychotherapy. They found that marriage or divorce, together with other relationship problems, was the second most important source of distress that therapist deal in their personal psychotherapy. In fact, a study carried out by Deutsch (1985) to investigate psychotherapists'

personal problems and how they deal with these problems revealed that 82% had experienced relationship problems and 47% received psychotherapy for their relationship problems at some point in their lives. The author argues that apart from facing relationship problems common in the general population, psychotherapists are dealing with relationship issues affected by their profession. For instance, spouses of therapists are refusing to receive couples therapy due to the concern that the counselor will take his colleague's side; or spouses of therapists complained that their partners are "over-processing" or "over-analyzing" their personal dynamics (p. 309).

Overall, it seems that mental health professionals are not immune to relationship problems suffered by many people today. Moreover, they seem to be dealing with additional side-effects of their profession which might, in turn, make them more vulnerable to such problems.

Research suggests that relationship problems are highly correlated with other psychiatric problems such as depression, dysthymia, anxiety disorders and alcohol dependence (Whisman, 1999). Although it is not yet clear whether relationship problems precede or follow other psychiatric disorders, Johnson (2002) suggests that relationship problems can be dated back to one's attachment pattern and hence attachment processes can be held responsible for other psychological difficulties in the future. Furthermore, there is increasing evidence in favor of the relationship between secure attachment and psychological well being (Hazan & Shaver, 1990; Priel & Shamai, 1995). Taken from this perspective, it can be argued

that commonly experienced relational and psychiatric problems by mental health professionals can be traced back to their attachment patterns.

1.2. Attachment Patterns of Mental Health Professionals

1.2.1. History and Development of Attachment Theory

History of attachment theory can be traced back to John Bowlby's investigations of the developmental origins of child and adult psychopathology. Bowlby was basically interested in children's reaction towards separation from a significant other and the effect of this separation on their later development. His observations of these children led him to develop his attachment theory which was a major shift from the dominant psychoanalytic thinking of that time (Hinde & Stevenson-Hinde, 1991).

In his attachment theory, Bowlby (1977) emphasizes "the propensity of human beings to make strong affectional bonds to particular others" (p. 201). He claims that the infant forms an attachment bond to his caregiver in order to ensure proximity in dangerous and threatening situations. More contemporary researchers perceive attachment as a continuously functioning system which serves to maintain the child's sense of security (Ainsworth, 1989; Sroufe & Waters, E., 1977). The extent to which the infant trusts his caregiver as a security source therefore determines the quality of the attachment relationship.

As a result of her observations of children's reactions towards separation from their mothers in a laboratory setting, Ainsworth (1989) came up with three categories of infant attachment: secure, anxious-resistant, and avoidant. Children with secure attachment style feel some

discomfort after separation from their caregiver but they are easily comforted by their caregivers when they return. Anxious-resistant infants show great amount of distress when their caregiver leaves the room and they show ambivalent behaviors towards them when they return. They are also difficult to soothe when the caregiver returns. Infants classified as avoidant show no sign of distress during separation and they are also indifferent towards their caregiver on reunion.

Bowlby (1973) asserts that children internalize their relationship with caregivers and this early relationship becomes model for their later adulthood relationships. He calls these internal representations as "internal working models" and claims that these working models are characterized by two basic elements: "(a) whether or not the attachment figure is judged to be the sort of person who in general responds to calls for support and protection; (b) whether or not the self is judged to be the sort of person towards whom anyone, and the attachment figure in particular, is likely to respond in a helpful way" (p.204). The first statement is related to the way the child perceives other people whereas the second statement is related to the way the child perceives himself.

1.2.2. Adult Attachment

A central premise of Bowlby's attachment theory is that attachment style continues to be of central importance throughout the person's life. Research supports the continuity of attachment patterns in later relationships (eg. Bowlby, 1973; Hamilton, 2000; and Waters, Hamilton, & Winfield, 2000).

Bartholomew and Horowitz (1991) propose a four-category adult attachment classification based on Bowlby's dyadic internal working models of the self and other. The authors claim that if the person's perception of the self and other can be dichotomized as positive and negative, then four combinations can be possible. These are secure, preoccupied, dismissing, and fearful attachment styles.

Securely attached people perceive themselves as worthy and others as open and responsive towards them. Preoccupied people perceive themselves as unworthy and others as valuable. People in this category try to achieve their self-confidence through gaining acceptance of significant others. People with dismissing attachment style have a sense of self-worth together with a negative perception of significant others. They try to maintain their independence and refrain from close relationships in order to avoid future disappointment. Fearfully attached people have a negative sense of self and they also expect others to be unresponsive and rejecting towards them. They fear and avoid close relationships since they expect these relationships to be harmful to them (Bartholomew & Horowitz, 1991).

According to Bartholomew and Horowitz (1991), although people in both dismissing and fearful attachment patterns avoid close relationships, they differ in the extent to which they require others to maintain self worth. Even though they avoid others, fearfully-attached individuals are highly dependent on others to maintain a positive sense of self. Similarly, preoccupied and fearful individuals both require others to retain a positive sense of self; but they differ in terms of their willingness to become

involved with others. People in preoccupied attachment category try to be close to others for satisfying their dependency needs whereas those in fearful attachment category avoid these kinds of relationships to protect themselves from disappointment (Bartholomew & Horowitz, 1991).

1.2.3. Attachment in Mental Health Professionals

Within the vast amount of attachment literature, studies on attachment styles of mental health professionals are rather limited. In addition, within this limited studies, the main aim was not to understand inner experiences of mental health professionals but to investigate how their attachment patterns affect the therapeutic relationship and therefore the wellbeing of the patient (eg, Black, Hardy, Turpin, & Parry, 2005).

Lieper and Casares (2000) investigated self-reported attachment styles of a group of British clinical psychologists. Seventy percent of the sample rated themselves as securely attached, 18 % as avoidantly attached, and 9 % as ambivalently attached. The authors compared these results to general population norms and concluded that clinical psychologists are more prone to rate their attachment style as secure.

In a similar study, Ligiéro and Gelso (2002) explored attachment patterns of a group of master's and doctoral level clinical and counseling psychology students in terms of their attachment styles via 7-point Likert type Relationship Scales Questionnaire. In their study, 90 % of the therapists scored above 4 on secure attachment measures, 27 % scored above 4 on fearful attachment measures, 24 % scored above 4 on preoccupied attachment measures, and 18 % scored above 4 on dismissive

attachment measures. The results of this study also pointed to a significant higher prevalence of secure attachment in psychotherapists compared to the general population.

1.3. Burnout among Mental Health Professionals

1.3.1. History and Development of the Concept

The term "burnout" was first defined by Freudenberger (1975), who was a psychiatrist working in a health care clinic. He described burnout as "failing, wearing out, or becoming exhausted through excessive demands on energy, strength, or resources" (p. 73). The concept was further developed by Maslach and Jackson (1981) and they defined burnout as "a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do 'people work' of some kind (p.99).

The initial articles about burnout were written by Freudenberger (1975) and Maslach (1976) and they were largely based on clinical interviews or case studies. There were several commonalities among these early burnout studies and interviews. First, it was observed that providing human services is a challenging task and emotional exhaustion is highly prevalent among care providers working under job overload. Second, people suffering from burnout also reported depersonalization or cynicism as a way of dealing with work stress. That is, they were emotionally distancing themselves from their clients in order to refrain from being emotionally overwhelmed. Although they were largely unempirical, these initial studies

provided a better understanding of burnout phenomenon (Maslach, Schaufeli, & Leiter, 2001).

Beginning with 1980s, burnout studies moved to a more empirical basis. Researchers began to use more quantitative methods, and several scales and questionnaires were developed. One of the most widely used burnout scales is the Maslach Burnout Inventory (MBI), developed by Maslach and Jackson (1981). Maslach Burnout Inventory was designed to measure three major components of burnout: emotional exhaustion, depersonalization, and reduced personal accomplishment. According to the authors, emotional exhaustion is the most important feature of burnout and it is characterized by feeling emotionally exhausted and drained as a result of one's work with people needing their services. Depersonalization (or cynicism) is feeling of detachment towards one's clients. It is an attempt to objectify the client in order not to get emotionally overinvolved with him/her. Reduced personal accomplishment includes feelings of reduced accomplishment and dissatisfaction with one's work and lack of motivation.

Although there seem to be three major components of burnout, signs and indicators of burnout are manifold. Kaçmaz (2005), in her review of the burnout literature, groups symptoms of burnout under five major levels: psychophysiological, psychological, behavioral, and organizational. Psychophysiological symptoms consist of fatigue, lack of energy, frequent headaches and sleep problems, respiratory problems, weight loss, and increase in psychosomatic complaints. Psychological symptoms include emotional exhaustion, difficulty in regulating emotions such as anger and

frustration, anxiety, restlessness, occasional difficulties with cognitive functions such as attention and memory, reduced self esteem, indecisiveness and apathy. Behavioral symptoms include behaviors and attitudes towards work such as late coming and absenteeism, postponing or procrastination, reduce in the quality of the service the person provides, cynical attitude toward one's colleagues and clients, tendency to quit job, spending work hours with other tasks which are not related to work, etc. Organizations in which burnout is highly prevalent also display certain characteristics. These are increase in severance and job turnover, increase in absenteeism, complaints from clients or their relatives with regard to the quality of services they receive, ambiguity in terms of the criteria for promotions or rewards, lack of positive reinforcement, increase in interpersonal and physiological problems among the personnel, and conflict among the employees.

1.3.2. Burnout among Mental Health Professionals

Maslach and Jackson (1981) state that mental health professionals are particularly at risk for burnout due to the nature of their work. That is, mental health professionals spend a considerable amount of time dealing with emotional, relational and/or physical problems of their clients. The slow and erratic nature of this relationship, together with dealing with intense emotions such as anger, frustration, despair or embarrassment impinge a large amount of stress to the mental health worker and make him considerably vulnerable to burnout.

Kottler (1993) suggests that burnout is an almost inevitable side effect of practicing psychotherapy. According to him, burnout manifests itself as reluctance to talk about work in social settings, unwillingness to reply messages and calls, inappropriate gladness after a session has been canceled, cynicism, lack of enthusiasm together with unwillingness to begin a new work day. Kottler states that the most serious impairment that burnout results in is refusal to accept it as a problem and avoidance of seeking help.

Ackerley, Burnell, Holder, and Kurdek (1988) examined burnout among doctoral-level psychologists. The results showed that psychologists experienced significantly higher amount of emotional exhaustion and depersonalization together with significantly lower amount of personal accomplishment compared to the norms. In particular, more than one third of the sample was found to experience high levels of emotional exhaustion and depersonalization. A more recent study investigated burnout rates among a group of marriage and family therapists (Rosenberg & Pace, 2006). The study revealed that therapists experience low to moderate levels of burnout.

Evans et al. (2006) reported that social workers working in mental health settings experienced significantly higher emotional exhaustion and depersonalization together with significantly lower personal accomplishment compared to the norms of mental health professionals. Edwards et al. (2006) investigated burnout among a group of mental health nurses working in community settings. The authors found that overall, the group experienced high amount of emotional exhaustion and

depersonalization together with lowered personal accomplishment. In a similar study, however, Hyrkäs (2005) found that mental health and psychiatry nurses suffered from emotional exhaustion but not depersonalization.

In a comparative study, Onyett, Pillinger and Muijen (1997) looked at different mental health occupation groups in terms of their self-reported burnout rates. They found that social workers, nurses, psychiatrists and clinical psychologists experienced high amount of emotional exhaustion whereas depersonalization was only high among psychiatrists.

Overall, studies that investigate burnout among mental health professionals came up with inconsistent results. According to Farber and Heifetz (1982), instead of trying to establish an overall burnout profile of mental health professionals, factors that influence or moderate burnout should be investigated.

1.3.2.2. Correlates of Burnout among Mental Health Professionals

Age is one of the most commonly studied demographic correlates of burnout. In general, as age increases, the amount of experienced burnout decreases (Ackerley et al., 1988; Rosenberg & Pace, 2006). In terms of gender, the findings are controversial. Some studies (eg. Edwards et al., 2006; Rosenberg & Pace, 2006; Vredenburgh, Carlozzi, & Stein, 1999) suggest that females experience less burnout, especially in terms of depersonalization although there are also studies who did not find such a difference (eg. Ackerley et al., 1988).

The effect of factors related to the nature of the relationship between the service provider and their clients on burnout have also been investigated. In general, slow and erratic nature of the therapeutic work, dealing with intense negative emotions (such as anger, envy, and fear), working with clients who have more severe pathology, overinvolvement with work, the risk of therapy relationship to raise or elevate therapist's own personal issues have all been identified as risk factors for burnout (Ackerley et al., 1988; Farber & Heifetz, 1982; Taylor & Barling, 2004).

With respect to factors associated with work setting, income was found to correlate positively with personal accomplishment and negatively with emotional exhaustion and depersonalization. Furthermore, the longer hours the clinician works per week, the higher amount of burnout he experiences. In addition, those working in private practice seem to be less likely to suffer from burnout than those working in public sector (Ackerley et al., 1988; Farber & Heifetz, 1982; Rosenberg & Pace, 2006).

Recently, the relationship between clinical supervision and burnout has also been investigated. Edwards et al. (2006) and Hyrkäs (2005) found that mental health nurses' evaluations of the efficacy of their supervision is a significant predictor of their burnout scores; with those rated their supervision as effective were less likely to suffer from burnout. A similar study, however, found that effective clinical supervision correlated positively personal accomplishment but also emotional exhaustion (Hyrkäs, Appelqvist-Schmidlechner, & Haataja, 2006). The authors concluded that

further research is warranted in order to understand the mechanisms underlying the relationship between clinical supervision and burnout.

The mental health workers' relationships with their organization also seem to correlate with burnout. Specifically, those who have to deal with job insecurity, problems with management and the system, overwork pressures, and lack of adequate resources and support are more likely to experience distress and burnout (Farber & Heifetz, 1982; Taylor & Barling, 2004).

1.3.2.1. Burnout Research in Turkey

Oğuzberk and Aydın (2008) compared psychiatrists, psychologists and psychiatry nurses working in state hospitals in Turkey in terms of their burnout scores. Their results showed that nurses experience more emotional exhaustion than psychologists; and psychiatrists scored higher on depersonalization subscale than psychologists. There was no between group difference in terms of personal accomplishment. The authors also found that married practitioners experience more emotional exhaustion compared to singles. Age and gender, on the other hand, did not seem to relate to any indicators of burnout. In addition, as income increased, depersonalization and total burnout score decreased.

Sinat (2007) investigated burnout among a group of female nurses working in psychiatry clinics in terms of their burnout scores as well as factors that might correlate with experienced burnout. Her findings indicated that none of the mean scores for all three burnout subscales (emotional exhaustion, depersonalization, and personal accomplishment)

indicated burnout. Marital status and level of university degree did not correlate with any of the burnout scores. In terms of age, however, there was a significant correlation; with older nurses experiencing less emotional exhaustion and more personal accomplishment than the younger ones.

In a cross-cultural study, Havle, İlnem, Yener and İster (2009) investigated psychiatrists from different nations and locations who have attended to a psychiatry congress in Turkey in terms of their burnout scores. Overall, emotional exhaustion and depersonalization scores of the sample were found to be high. Psychiatrists experienced high levels of personal accomplishment as well. The authors did not find any relationship between burnout and sociodemographic variables such as age, gender, and marital status. However, burnout scores were higher among psychiatrists who used alcohol, had lower income, are unsatisfied with their work conditions, and did not receive sufficient amount of appreciation from their superiors.

1.3.3. The Relationship between Attachment Style and Burnout

The need to study the relationship between attachment and burnout has been proposed by Pines (2004). The author claims that securely attached individuals are better able to evaluate stressing experiences and cope with them in a positive and productive manner. However, those with insecure attachment styles lack the resources for coping with stress and are therefore more likely to experience burnout.

Simmons, Gooty, Nelson, and Little (2009) investigated a group of employees in an assisted living center and found a significant negative relationship between secure attachment and burnout. A similar study carried

out by Ronen and Mikulincer (2009) also revealed that increased levels of attachment anxiety and avoidance are related to higher levels of job burnout.

In a cross-cultural study, Pines (2004) looked at the relationship between attachment style and burnout among five groups of employees from different cultures. She consistently found a negative relationship between secure attachment and burnout in addition to a positive relationship between insecure attachment (anxious or avoidant) and burnout. In a similar study, Vanheule and Declercq (2009) studied the relationship between attachment style and three components of burnout: Emotional exhaustion, depersonalization, and decreased personal accomplishment. Their study revealed a negative relationship between secure attachment and all three burnout components. Preoccupied and fearful attachment has been found to correlate positively with all three burnout measures whereas dismissing attachment style had a positive relationship with only depersonalization.

1.3.4. The Relationship between Mental Health and Burnout

Maslach and Jackson (1981) stated that in addition to a reduce in the quality of care and problems related to work environment such as absenteeism, burnout seems to be related to “various self-reported indices of personal distress, including physical exhaustion, insomnia, increased use of alcohol and drugs, and marital and family problems” (p. 100). The authors added that although burnout and mental health are different concepts, they are highly related.

Golembiewski, Llyod, Scherb and Muncenrider (1992) investigated the relationship between mental health and burnout among a sample of

police officers. Their results revealed that deterioration of mental health was related to increased burnout. A similar study by Peterson et al. (2008) revealed that among a group of health care workers in Sweden, those with high burnout scores suffered more from anxiety, depression, and sleep and memory problems compared to those with low burnout scores.

In order to identify the direction of the relationship between mental health and burnout, Tang, Au, Schwarzer and Schmitz (2001) analyzed burnout and mental health profiles among Chinese teachers by means of structural equation modeling. The authors asserted that a person's current burnout level has a direct effect on his future mental health. The authors stated that these findings should be replicated across different groups and therefore caution must be taken while interpreting them.

Researchers have also begun to explore the relationship between mental health and burnout among mental health professionals. In a study with mental health social workers, for instance, Evans et al. (2006) found a strong relationship between emotional exhaustion and psychiatric symptomatology.

1.4. Present Study

The aim of this study is to investigate psychiatric symptomatology, attachment styles and burnout rates as well as the relationships between these variables among mental health professionals in Turkey. Based on previous research, the following hypotheses have been formulated:

1. It is predicted that psychiatric symptom levels of mental health professionals in Turkey will be similar to that of the normal population.
2. It is predicted that mental health professionals in Turkey will display a higher frequency of secure attachment together with a lower frequency of insecure attachment compared to the general population.
3. It is predicted that mental health professionals in Turkey will display burnout in the form of high rates of emotional exhaustion and depersonalization together with lowered personal accomplishment.
4. Securely attached professionals are expected to display less amount of psychiatric symptomatology compared to insecurely attached professionals.
5. Securely attached professionals are also expected to experience less emotional exhaustion and depersonalization and more personal accomplishment compared to insecurely attached professionals.
6. A significant positive correlation between psychiatric symptomatology and emotional exhaustion and depersonalization; together with a significant negative correlation between psychiatric symptomatology and personal accomplishment is expected.

In addition to these hypotheses, sociodemographic, occupational, and professional variables (such as age, gender, years of clinical experience, clinical supervision, etc.) and the way they are related to burnout and

psychiatric symptomatology among mental health professionals in Turkey will also be investigated.

CHAPTER 2. METHOD

2.1. Participants

The participants of the study consisted of mental health professionals such as psychologists, psychiatrists, counselors, social workers, etc. who are actively working in the field. Overall, 245 participants contributed to this study. There were 50 males and 195 females. Their ages ranged from 22 to 61, with a mean of 32.04 (SD= 8.1). 48.4 % of the sample was single whereas 51.6 % was either married or living together with a partner. A large number of participants were living in Istanbul (72.2 %). The remaining was residing in Ankara (9 %), Izmir (4.9 %) and other cities in Turkey (13.1 %).

In terms of their educational and professional characteristics, 9.39 % of the sample had a PhD degree, 30.20 % had a master's degree, and 60 % had a B.A. degree. A large number of participants indicated themselves as psychologist (42.04%), 19.59 % as clinical psychologist, 19.59 % as psychotherapist, 10.20 % as psychological counselor, 11.62 % as psychiatrist. Other commonly indicated titles were M.A. psychological counselor (7.35 %), psychiatry intern (6.12 %), psychoanalyst or psychoanalyst candidate (5.31 %), psychiatry nurse (2.04 %), etc. The kind of work place the sample was working in showed a great variation. They were mostly working in private counseling or psychotherapy centers and private office (37.8 %), state hospitals (9.4 %), psychiatry clinics in state hospitals (9.4 %), special education and rehabilitation centers (7.4 %), universities (11.4 %), state mental hospitals (6.5 %), private hospitals (6.1 %), NGOs (6.1 %), etc. Their mean year of clinical experience was 6.80

(SD= 6.98) with a minimum of 0 and a maximum of 38 years. (For the details of socio-demographic and educational/professional characteristics of the sample, see Tables 1, 2, and 3 in the Results section).

2.2. Materials

Brief Symptom Inventory (BSI). This test, developed by Derogatis and Spencer (1982), is a self-report inventory which looks at the prevalence and severity of psychological symptoms. These symptoms are: Somatization, Obsessive-Compulsive tendencies, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism. Respondents indicate the extent to which each of these symptoms they experienced within the last 7 days on a 5-point Likert scale (ranging from 0= not at all to 4=extremely). In addition to nine symptom clusters, there are 3 global indexes that can be obtained from the BSI scores. These are; the General Severity Index (GSI), which examines the current level of distress; the Positive Symptom Distress Index (PSDI), which measures the intensity of the symptoms, and the Positive Symptom Total (PST), which is basically the total number of symptoms the subject reports (as cited in Bore et al., 2008).

According to Deragotis and Melisaratos (1983) the BSI has high test-retest reliability, ranging from .68 for Somatization to .91 for Phobic Anxiety. Cronbach alpha coefficients were found to range between .71 for Psychoticism and .85 for Depression. The correlations between BSI and Minnesota Multiphasic Personality Inventory (MMPI) clinical scales are found to be over .30, suggesting that BSI has good criterion-related validity.

The Brief Symptom Inventory was investigated by many researchers in term of its reliability and validity. In a study with 501 forensic psychiatry patients, Boulet & Boss (1991) found that Cronbach alpha indexes of the BSI ranged from .75 for Psychoticism to .89 for Depression, suggesting that it has a high degree of internal consistency. They also tried to assess the convergent validity of the BSI with MMPI and found that each BSI symptom index is moderately to highly correlated with its counterpart MMPI subscales. Morlan and Tan (1998) compared the BSI with the Brief Psychiatric Rating Scale (BPRS), in order to determine its construct validity. Their results revealed a significant correlation between BPRS and BSI total scores, suggesting that the BSI has a significant degree of construct validity.

The BSI was adapted to Turkish population by Şahin and Durak (1994). Internal consistency of the inventory was found to range between .96 and .95 for total scores and between 0.55 and 0.86 for subscale scores. In terms of criterion validity, the correlation between BSI and Beck Depression Inventory ranges between .34 and .70. Factor analytic studies of the Turkish version revealed 5 major factors: Anxiety, Depression, Negative Self, Somatization, and Hostility (Sahin & Durak, 1994) (See Appendix A).

Relationship Scales Questionnaire (RSQ). This is a 30-item self-report questionnaire which assesses adults' attachment patterns (Griffin & Bartholomew, 1994). The respondents are asked to rate how much they agree with each of the statements. The results indicate which attachment pattern a particular respondent fits into: secure, preoccupied, dismissing,

and fearful. Each attachment pattern is related to a particular conception of self and other.

Griffin and Bartholomew (1994) found that internal consistency scores of RSQ ranged from .41 for secure type to .70 for dismissing type. In terms of convergent validity, RSQ was compared to The Relationship Questionnaire (Bartholomew & Horowitz, 1991) which is another attachment measure. The validity coefficients were found to range between .22 and .50.

RSQ was adapted to Turkish by Sümer & Güngör (1999). Test-retest reliability of the Turkish version was found to vary between .54 and .78. Internal consistency coefficients, on the other hand, ranged between .27 and .61.

Maslach Burnout Inventory (MBI). This test, developed by Maslach and Jackson (1981), intends to measure three elements of the burnout syndrome: emotional exhaustion, depersonalization and reduced personal accomplishment. MBI is a self-report questionnaire which contains 22 items, each ranged on a 7-point Likert scale.

Emotional exhaustion, which is measured by 9 items, is characterized by feeling emotionally overwhelmed and worn out by work. Depersonalization is measured by 5 items and refers to one's feelings of detachment and lack of empathy towards those receiving their services. The 8 items in the Personal Accomplishment subscale measure one's feelings of competency and tendency to perceive oneself positively with respect to his work with other people. High scores on the emotional exhaustion and

depersonalized subscales combined with a low score on the personal accomplishment subscale indicate burnout (Maslach, Jackson, & Leiter, 1997).

The inter-item consistency rates for the three subscales of MBI were found to range between .71 and .90. Test-retest reliability of MBI was found to range between .54 and .60 (Jackson, Schwab, & Schuler, 1986). In a study of validity of the Maslach Burnout Inventory, Schaufeli and Van Dierendonck (1993) confirmed the 3-factor structure of the MBI. Findings showing that correlations between MBI subscales and Burnout Measure (BM; developed by Pines and Aronson, 1988) range between .37 and .76 indicate the congruent validity of the MBI. In order to assess the discriminant validity of the MBI, Maslach and Jackson (1981) looked at the relationship between the scores of MBI subscales and job satisfaction and found that there are moderate to low correlations between burnout scores and job satisfaction and these correlations accounted for less than 6 percent of the variance. The authors argued that this finding points to the discriminant validity of the MBI.

MBI was translated to Turkish by Ergin (1992). After applying the form to a sample of 235 which included doctors, nurses, teachers, lawyers, police officers and civil officials, 7-point rating for each item was found to be inappropriate for Turkish culture and therefore replaced with the 5-point rating.

Ergin (1992) found that Cronbach alpha rates for each subscales of the Turkish version are .83 for emotional exhaustion, .72 for reduced

personal accomplishment, and .65 for depersonalization subscales. Test-retest reliability rates were found to be .83 for emotional exhaustion, .71 for depersonalization, and .67 for personal accomplishment subscales. Factor analysis also confirmed the 3-factor structure of the Turkish version. In order to assess the convergent validity of the Turkish version of the MBI, Çam (1992) compared the self-ratings of nurses with their friends' ratings of them. There was not a statistically significant difference between the two ratings. This finding led the author to argue that Turkish version of the MBI is a valid measure of burnout.

2.3. Procedure

This study was part of a larger study which also investigated sociodemographic characteristics, educational background, and social identities of mental health professionals in Turkey. The overall survey consisted of five modules (See Appendix A). The first module investigated the sociodemographic characteristics. The second module looked at the educational background of the participants. The third module investigated professional characteristics whereas the fourth module explored social identity. The fifth module particularly looked at psychiatric symptomatology, burnout rates, and attachment styles of the sample, which was the main focus of this article. The first page of the survey included a brief description of the study together with necessary contact information. Overall, it took 30 to 40 minutes to complete the survey.

The survey was prepared with a computer software called Webropol (2002). The public link of the survey, together with an introductory

statement about the content and purpose of the study, was sent to major email groups joined by mental health professionals. 204 participants filled in the survey this way. This number was considered insufficient for the purposes of this study. Therefore, we converted the survey into a Word format, printed and distributed them to major hospitals and counseling and psychotherapy clinics in Istanbul. Each survey was sent in a closed envelope with a stamp for participants to send it back. Overall, 264 surveys were distributed that way. 41 surveys were filled in and sent back, with a response rate of 15.53 %.

CHAPTER 3. RESULTS

3.1. Description of the Sample

Overall, 245 participants completed the survey and were therefore included in the analyses. The mean age of the sample was 32 (SD=8.1). 79.6 % of the sample was female and 20.4 % was male. More than half of the sample was single (58.4 %), and 41.6 % was either married or cohabiting with a partner. 42.4 % did not have any children, 44.1 % have one child, and 13.5% have two or more children.

In order to be able to make comparisons among different occupation groups, the sample was divided into six major categories: The first group was the psychologists with BA degree and/or with a MA degree rather than clinical psychology (n=92, 37.6%). The second was formed by the psychiatrists, both the interns and the residents (n=31, 12.7%). The third group was defined by the psychological counselors who have a bachelor's degree in the field of guidance and psychological counseling (n=29, 11.8%). In the fourth group, clinical psychologists who have a master's degree in the field of clinical psychology were included (n=51, 20.8%). The fifth group was formed by the clinical psychology MA students (n=29, 11.8%), and the last group was named as "others" who did not match the previous groups, but others, such as social workers, psychiatry nurses and etc (n=13, 5.3%). Table 1 shows sociodemographic characteristics of the overall sample and each professional group.

In terms of educational background, all participants had at least B.A. degree. 39.5 % of the sample had an M.A. degree and 9.3 % had a PhD.

degree. In order to be able to make three-level (BA-MA-PhD) comparisons, psychiatry interns were grouped as MA level, whereas psychiatry residents as PhD level. (See Table 2 for details and between group differences in terms of educational background).

With regard to their active clinical practice, the most frequently mentioned labels were "psychologist" (42.4%), "psychotherapist" (20%), "clinical psychologist" (18.8 %), and "psychological counselor" (10.2 %). Table 3 demonstrates the frequency of these labels among the sample and six professional groups.

Table 1. Sociodemographic Characteristics

Sociodemographic Characteristics	Total (n=245)	Groups 1 Psychologists (n=92)	2 Psychiatrists (n=31)	3 Psych. Counselors (n=29)	4 Clinical Psych. (n=51)	5 Cli.Psy. M.A. st. (n=29)	6 Others (n=13)	P (NS, if p>.05)
Mean Age (SD)	32.0 (8.1)	29.5 (6.9)	37.0 (8.6)	34.2 (7.3)	33.6 (8.5)	27.3 (5.1)	37.8 (9.3)	.000 1=5<2=3=4=6
Age Groups (%)								.000
22-25	21.7	37.0	---	6.9	---	55.2	8.3	
26-30	34.8	31.5	35.5	27.6	52.9	27.6	16.7	
31-35	18.9	16.3	16.1	37.9	19.6	10.3	16.7	
36-40	10.2	7.6	12.9	13.8	9.8	3.4	33.3	
40+	14.3	7.6	35.5	13.8	17.6	3.4	25.0	
Gender (%)								.000
Female	79.6	85.9	38.7	79.3	88.2	82.8	92.3	
Male	20.4	14.1	61.3	20.7	11.8	17.2	7.7	
Marital Status (%)								.027
Married/cohabiting	41.6	34.8	54.8	55.2	49.0	20.7	53.8	
Single	58.4	65.2	45.2	44.8	51.0	79.3	46.2	
Number of Children (%)								NS
0	42.4	40.2	38.7	34.5	54.9	44.8	30.8	
1	44.1	47.8	35.5	55.2	33.3	51.8	38.5	
2	10.2	8.7	19.4	10.3	7.8	3.4	23.1	
3	3.3	3.3	6.5	---	3.9	---	7.7	
Number of Divorce (%)								NS
0	52.7	45.7	54.8	65.5	53.8	48.3	61.5	
1	44.5	54.3	35.5	31.0	42.5	51.7	38.5	
2	2.9	---	9.7	3.4	3.8	---	---	

Table 1. Sociodemographic Characteristics (cont'd)

Sociodemographic Characteristics	Total (n=245)	Groups 1 Psychologists (n=92)	2 Psychiatrists (n=31)	3 Psych. Counselors (n=29)	4 Clinical Psych (n=51)	5 Cli.Psy. M.A. st. (n=29)	6 Others (n=13)	P (NS, if p>.05)
Birth Place (%)								.000
Metropolis	53.9	55.4	32.3	55.2	68.6	65.5	7.7	
City	26.1	22.8	48.4	20.7	21.6	27.6	23.1	
Town	12.7	14.1	9.7	17.2	5.9	6.9	38.5	
Village or District	7.3	7.6	9.7	6.9	3.9	---	30.8	
City of Residence (%)								.009
İstanbul	72.2	59.8	80.6	82.8	74.5	89.7	69.2	
Ankara	9.0	10.9	16.1	6.9	5.9	3.4	7.7	
İzmir	4.9	4.3	---	3.4	9.8	---	15.4	
Bursa	2.4	2.2	---	---	5.9	3.4	---	
Other	11.4	22.8	3.2	6.8	3.9	3.4	7.7	

Groups: 1: Those who have a B.A. or M.A. degree other than clinical psychology in psychology
2: Psychiatry interns and residents
3: Those who have a B.A. degree in Guidance and psychological Counseling
4: Those who have clinical psychology M.A. degree
5: Clinical psychology M.A. students
6: Others (eg. Social workers, nurses etc.)

Table 2. Educational Background

Degrees (%)	Total (n=245)	Groups 1 Psychologists (n=92)	2 Psychiatrists (n=31)	3 Psych. Counselors (n=29)	4 Clinical Psych (n=51)	5 Cli.Psy. M.A. st. (n=29)	6 Others (n=13)	P (NS, if p>.05)
Any university degree	100.0	100.0	100.0	100.0	100.0	100.0	100.0	NS
BA degrees								
Psychology BA	67.3	98.9	---	13.8	90.2	82.8	---	.000
MD	13.1	---	100.0	---	2.0	---	---	.000
Psychological Counseling BA	12.7	1.1	---	79.3	3.9	17.2	---	.000
Pedagogy BA	1.6	---	---	10.3	---	---	7.7	.001
Social Service BA	0.8	---	---	---	---	---	15.4	.000
Other BA	6.5	1.1	3.2	3.4	2.0	6.9	76.9	.000
MA degrees								
Clinical Psychology MA	20.8	---	---	---	100.0	---	---	.000
Neuropsychology MA	0.8	1.1	---	3.4	---	---	---	NS
Health psychology MA	0.8	2.2	---	---	---	---	---	NS
Other psychology MA	3.3	5.4	---	10.3	---	---	---	NS
Psychological Counseling MA	5.3	1.1	---	41.4	---	---	---	.000
Forensic Science MA	1.6	4.3	---	---	---	---	---	NS
Pedagogy MA	0.4	1.1	---	---	---	---	---	NS
Other MA	6.5	7.6	---	6.9	2	---	46.2	.000

Table 2. Educational Background (cont'd)

Degrees (%)	Total (n=245)	1 Psychologists (n=92)	2 Psychiatrists (n=31)	3 Psych. Counselors (n=29)	4 Clinical Psych (n=51)	5 Cli.Psy. M.A. st. (n=29)	6 Others (n=13)	P (NS, if p>.05)
	Groups							
PhD degrees								
Adult Psychiatry MD	5.3	---	41.9	---	---	---	---	.000
Child-Adolescent Psychiatry MD	0.8	---	6.5	---	---	---	---	.016
Clinical Psychology PhD	1.6	---	---	---	7.8	---	---	.009
Neuropsychology PhD	---	---	---	---	---	---	---	NS
Psych Counseling PhD	---	---	---	---	---	---	---	NS
Forensic Science PhD	---	---	---	---	---	---	---	NS
Pedagogy PhD	---	---	---	---	---	---	---	NS
Other Psychology PhD	0.4	---	---	---	2.0	---	---	NS
Other PhD	1.2	---	---	3.4	---	---	15.4	.000

Groups: 1: Those who have a B.A. or M.A. degree other than clinical psychology in psychology
2: Psychiatry interns and residents
3: Those who have a B.A. degree in Guidance and psychological Counseling
4: Those who have clinical psychology M.A. degree
5: Clinical psychology M.A. students
6: Others (eg. Social workers, nurses etc.)

Table 3. Active Clinical Practice

Active Clinical Practice (%)	Total (n=245)	1 Psychologists (n=92)	2 Psychiatrists (n=31)	3 Psych. Counselors (n=29)	4 Clinical Psych (n=51)	5 Cli.Psy. M.A. st. (n=29)	6 Others (n=13)	p (NS, if p>.05)
		Groups						
Adult psychiatrist	7.4	---	58.1	---	---	---	---	.000
Child psychiatrist	1.2	---	9.7	---	---	---	---	.001
Adult psychiatry intern	5.3	---	41.9	---	---	---	---	.000
Child psychiatry intern	0.4	---	3.2	---	---	---	---	NS
Psychologist	42.4	82.6	---	3.4	9.8	75.9	---	.000
Clinical Psychologist	18.8	---	---	---	86.3	6.9	---	.000
Neuropsychologist	0.4	---	---	---	2.0	---	---	NS
Health Psychologist	1.2	3.3	---	---	---	---	---	NS
Psychological Counselor	10.2	2.2	---	51.7	3.9	17.2	7.7	.000
Psych. Counselor MA	7.3	3.3	---	44.8	3.9	---	---	.000
Social Worker	0.8	---	---	---	---	---	15.4	.000
Pedagogue	0.8	---	---	3.5	---	---	7.7	.038
Pedagogue MA	0.4	---	---	3.5	---	---	---	NS
Psychoanalyst	2.0	---	9.7	---	3.9	---	---	.020
Psychoanalyst Candidate	3.2	2.2	9.7	---	2.0	6.9	---	NS
Psychotherapist	20.0	12.0	12.9	3.5	41.2	34.5	15.4	.000
Psychiatry Nurse	2.4	---	---	---	---	---	46.2	.000
Others	8.9	12.0	---	6.9	5.9	6.9	38.5	.003

Note: Some participants mentioned more than one title.

Groups: 1: Those who have a B.A. or M.A. degree in psychology other than clinical psychology
2: Psychiatry interns and residents
3: Those who have a B.A. degree in Guidance and psychological Counseling
4: Those who have clinical psychology M.A. degree
5: Clinical psychology M.A. students.
6: Others (eg. Social workers, nurses etc.)

Participants of this study work at a wide range of clinical settings in both full time and part time status. Those working full time were mostly employed in state hospitals (8.6 %), psychiatry departments of state hospitals (7.8 %), and state mental health hospitals (6.1 %). Private psychotherapy and psychological counseling centers (12.2 % each), on the other hand, were most frequently marked as part time work settings. Table 4 shows percentage of participants working in each clinical setting category in terms of both full time and part time status.

Table 4. Clinical Work Settings

Settings (%)	Total (n=245)		1 Psychologist (n=92)		2 Psychiatrist (n=31)		3 Psych. Counselors (n=29)		4 Clinical Psych (n=51)		5 Cli.Psy. M.A. st. (n=29)		6 Others (n=13)		P* (NS, if p>.05)
	FT	PT	FT	PT	FT	PT	FT	PT	FT	PT	FT	PT	FT	PT	
State Hospital	8.6	0.8	8.7	---	19.4	6.5	---	---	5.9	---	3.4	---	23.1	---	.003
State Hospital, Psychiatry Department	7.8	1.6	5.4	2.2	22.6	3.2	---	---	9.8	2.0	3.4	---	7.7	---	NS
State Mental Health Hospital	6.1	0.4	5.4	---	19.4	---	---	---	3.9	---	3.4	3.4	7.7	---	.032
Other State Institutions	5.3	0.4	9.8	1.1	---	---	---	---	2.0	---	6.9	---	7.7	---	NS
Private Psychological Counseling Center	4.5	12.2	3.3	10.9	---	---	20.7	17.2	2.0	17.6	---	20.7	7.7	---	.000
Private University	4.1	3.3	---	---	---	---	3.4	6.9	15.7	5.9	---	10.3	7.7	---	.000
Municipal Health Center	3.7	0.8	9.8	1.1	---	---	---	---	---	---	---	3.4	---	---	.038
Private Ed&Rehabil.Center	3.3	4.1	6.5	4.3	---	---	3.4	6.9	2.0	---	---	13.8	---	---	NS
Guidance Research Center	2.9	0.4	3.3	---	---	---	10.3	3.4	---	---	3.4	---	---	---	NS
State University	2.4	1.6	1.1	---	---	---	3.4	3.4	3.9	3.9	3.4	---	7.7	7.7	NS
Private Psychotherapy Cent.	2.0	12.2	2.2	5.4	3.2	3.2	3.4	6.9	2.0	33.3	---	17.2	---	---	.000
Courtroom	2.0	---	5.4	---	---	---	---	---	---	---	---	---	---	---	NS
Private Clinic	2.0	4.9	---	---	---	---	3.4	6.9	2.0	7.8	3.4	10.3	---	---	NS
Private Mental Health Hosp.	1.6	---	1.1	---	3.2	---	---	---	2.0	---	3.4	---	---	---	NS
Private Hospital	1.6	4.5	1.1	5.4	3.2	6.5	---	---	2.0	5.9	3.4	3.4	---	---	NS

Table 4. Clinical Work Settings (cont'd)

Groups

Settings (%)	Total (n=245)		1 Psychologists (n=92)		2 Psychiatrist (n=31)		3 Psych. Counselors (n=29)		4 Clinical Psych (n=51)		5 Cli.Psy. M.A. st. (n=29)		6 Others (n=13)		P* (NS, if p>.05)
	FT	PT	FT	PT	FT	PT	FT	PT	FT	PT	FT	PT	FT	PT	
State Elementary School	1.6	0.4	1.1	---	---	---	10.3	3.4	---	---	---	---	---	---	.009
Private Elemen. School	1.6	0.4	1.1	---	---	---	10.3	3.4	---	---	---	---	---	---	.009
Other Private Institutions	1.6	0.4	3.3	---	---	---	---	---	---	2.0	3.4	---	---	---	NS
State Hospital, Non-Psychiatry Department	1.2	---	2.2	---	---	---	---	---	---	---	---	---	7.7	---	NS
Private Medicine Hospital, Psychiatry Dep.	1.2	---	---	---	6.5	---	---	---	2.0	---	---	---	---	---	NS
NGO's	1.2	4.9	2.2	3.3	---	---	---	3.4	---	5.9	---	10.3	7.7	15.4	NS
Private Outpatient Clinic	0.8	1.2	1.1	1.1	---	---	---	---	2.0	---	---	6.9	---	---	NS
State High School	0.8	0.8	2.2	1.1	---	---	---	3.4	---	---	---	---	---	---	NS
Private Kindergarten	0.8	2.9	---	3.3	---	---	3.4	3.4	2.0	2.0	---	6.9	---	---	NS
Private High School	0.8	---	1.1	---	---	---	3.4	---	---	---	---	---	---	---	NS
Nursing Home	0.8	0.4	1.1	1.1	---	---	---	---	2.0	---	---	---	---	---	NS
Family Health Center	0.4	---	---	---	---	---	---	---	---	---	---	3.4	---	---	NS
Prison	0.4	0.4	---	1.1	---	---	---	---	---	---	3.4	---	---	---	NS
Private Teaching Inst.	---	0.4	---	1.1	---	---	---	---	---	---	---	---	---	---	NS
Women's Shelter	---	0.4	---	---	---	---	---	---	---	---	---	3.4	---	---	NS

**p is computed by combining part time and full time status for each group.*
Note: Some participants marked more than one clinical setting.

Groups: 1: Those who have a B.A. or M.A. degree other than clinical psychology in psychology.2: Psychiatry interns and residents.3: Those who have a B.A. degree in Guidance and psychological Counseling. 4: Those who have clinical psychology M.A. degree. 5: Clinical psychology M.A. students. 6: Others (eg. Social workers, nurses etc.)

3.2. Psychiatric Symptomatology

Table 5 shows overall scores as well as scores of six professional groups in terms of Brief Symptom Inventory (BSI) subscale and index scores. One-way analysis of variance (ANOVA) was used to compare each mean BSI score of six professional groups. There was no difference between the six groups in terms of their BSI scores at an alpha level of .05. That is, the groups did not differ with respect to their psychiatric symptom levels.

One sample t-test compared the sample BSI subscale score means to the mean scores for Turkish university students, established by Şahin and Durak (1994). The sample means for five subscale scores (Anxiety, Depression, Negative Self, Somatization, and Hostility) were found to be significantly different from Şahin and Durak's study (t (241) = -16.21, t (244) = -9.94, t (242) = -12.24, t (243) = -11.24, t (241) = -20.45, respectively; $p<.001$). Mean score of the sample for all five BSI subscale scores were significantly lower than expected means, suggesting that psychiatric symptomatology of the sample is significantly lower than the normal population (See Table 6).

Table 5. Psychiatric Symptomatology based on Brief Symptom Inventory (BSI)

Mean BSI Subscale Scores (SD)	Total (n=245)	Groups 1 Psychologists (n=92)	2 Psychiatrists (n=31)	3 Psych. Counselors (n=29)	4 Clinical Psych (n=51)	5 Cli.Psy. M.A. st. (n=29)	6 Others (n=13)	p (NS, if p>.05)
Anxiety	4.8 (4.8)	4.6 (4.3)	4.8 (5.4)	5.6 (6.7)	4.7 (4.6)	5.4 (4.7)	4.2 (3.9)	NS
Depression	8.0 (6.8)	8.3 (7.1)	7.4 (6.6)	8.2 (6.1)	7.3 (5.9)	9.7 (8.2)	5.9 (6.3)	NS
Negative Self	4.6 (5.0)	4.5 (5.1)	5.1 (4.9)	4.7 (5.8)	3.9 (4.1)	5.6 (5.3)	5.2 (5.9)	NS
Somatization	2.7 (2.7)	3.1 (2.6)	1.9 (2.2)	2.7 (3.8)	2.6 (2.5)	2.1 (2.1)	3.0 (3.3)	NS
Hostility	3.4 (3.2)	3.5 (3.4)	3.7 (3.2)	3.6 (4.0)	2.7 (2.5)	3.9 (3.3)	3.0 (2.6)	NS
Index Scores								
Global Severity Index	0.4 (0.4)	0.5 (0.4)	0.4 (0.4)	0.5 (0.4)	0.4 (0.3)	0.5 (0.4)	0.4 (0.4)	NS
Positive Symptom Total	15.8 (10.5)	15.8 (10.0)	15.9 (11.7)	15.9 (11.1)	15.1 (10.6)	17.1 (10.4)	15.0 (10.7)	NS
Positive Symptom Distress Index	1.4 (0.4)	1.4 (0.4)	1.3 (0.3)	1.4 (0.4)	1.3 (0.3)	1.4 (0.4)	1.3 (0.5)	NS

Groups:
1: Those who have a B.A. or M.A. degree other than clinical psychology in psychology
2: Psychiatry interns and residents
3: Those who have a B.A. degree in Guidance and psychological Counseling
4: Those who have clinical psychology M.A. degree
5: Clinical psychology M.A. students.
6: Others (e.g. Social workers, nurses etc.)

Table 6. Comparison of BSI subscale scores with Şahin & Durak' study (1994)

	Groups		
Mean BSI Subscale Scores (SD)	**1 Our sample (n=245)**	**2 Şahin & Durak (1994) (n=330)**	**p** (NS, if p>.05)
Anxiety	4.8 (4.8)	9.8 (8.3)	.000
Depression	8.0 (6.8)	12.3 (9.4)	.000
Negative Self	4.6 (5.0)	8.6 (8.0)	.000
Somatization	2.7 (2.7)	4.6 (4.3)	.000
Hostility	3.4 (3.2)	7.6 (5.5)	.000

3.2.1. The Relationship of BSI Subscale Scores with Some Categorical Variables

The relationship of BSI subscale scores with categorical variables was investigated. These variables are: gender, marital status, university degree, and current clinical supervision (whether the individual is currently receiving clinical supervision or not) (See Table 7).

A series of independent groups t-tests compared the mean BSI scores of male and female participants. Females scored significantly higher than males in terms of Anxiety, Depression, Negative Self, Somatization, Global Severity Index, Positive Symptom Total, Positive Symptom Distress Index (t (240) = 2.37, t (243) = 3.02, t (241) = 1.97, t (242) = 2.54, t (237) = 2.74, t (237) = 2.42, t (230) = 2.72, $p \leq .05$, respectively). The two groups, however, did not differ on their Hostility scores (t (240) = 1.94, $p > .05$).

Independent groups t-test results comparing BSI subscale scores according to marital status did not yield to significant results at an alpha level of .05, meaning that married or cohabiting individuals are not different from singles in terms of their psychiatric symptomatology.

In order to look at the effect of education, a one-way ANOVA compared the mean BSI scores of those who have Bachelor's., Master's., and doctoral degree as their highest education status. The test yielded statistically significant results for Depression, Hostility, Global Severity Index, and Positive Symptom Distress Index scores at an alpha level of .05 ($F\ (2, 242) = 3.49$, $F\ (2, 239) = 4.16$, $F\ (2, 236) = 3.70$, $F\ (2, 229) = 7.05$, respectively, $p < .05$). A Tukey HSD test indicated that the mean Depression, Hostility, Global Severity Index, and Positive Symptom Distress index of participants with B.A. degree was significantly higher than those who have a PhD. degree. In addition, M.A. level scored also significantly higher than PhD. level professionals in terms of their Positive Symptom Distress Index, suggesting these participants are experiencing their symptoms at a more intense level.

An independent groups t-test compared BSI scores of participants who are currently receiving clinical supervision and who are not. The only significant difference was found in terms of Positive Symptom Distress Index ($t\ (230) = -2.23$), with those who are not receiving clinical supervision experiencing their symptoms more intensely than those who are.

Table 7. The Relationship of BSI Subscale Scores with Some Categorical Variables

	Mean BSI Subscale Scores (SD)					**Index Scores (SD)**		
Categorical Variables	Anxiety	Depression	Negative Self	Somatization	Hostility	Global Severity Index	Positive Symptom Total	Positive Symptom Distress Index
Gender [p, (NS, if p>.05)]	.018	.003	.050	.012	NS	.007	.016	.007
Male (n=50)	3.4 (3.8)	5.4 (4.7)	3.4 (3.8)	1.8 (2.2)	2.6 (2.4)	.31 (.27)	12.7 (8.4)	1.2 (.28)
Female (n=195)	5.2 (5.0)	8.6 (7.1)	5.0 (5.2)	2.9 (2.8)	3.6 (3.4)	.47 (39)	16.7 (10.8)	1.4 (.39)
Marital status [p, (NS, if p>.05)]	NS	NS	NS	NS	NS	NS	NS	NS
Single (n=143)	5.1 (5.0)	8.6 (7.1)	4.9 (5.3)	2.6 (2.7)	3.4 (3.2)	.46 (.38)	16.4 (10.5)	1.4 (.37)
Married/cohabiting (n=102)	4.5 (4.6)	7.1 (6.2)	4.2 (4.5)	2.8 (2.8)	3.3 (3.3)	.41 (.35)	15.1 (10.5)	1.3 (.37)
University Degree [p, (NS, if p>.05)]	NS	.032 (3<1)	NS	NS	.017 (3<1)	.026 (3<1)	NS	.001 (3<1=2)
B.A. (n=120)	5.3 (4.6)	8.9 (7.5)	5.1 (5.4)	3.0 (2.7)	3.9 (3.5)	.50 (.40)	16.8 (10.1)	1.4 (.42)
M.A. (n=103)	4.7 (5.0)	7.6 (5.9)	4.5 (4.6)	2.5 (2.8)	3.1 (2.9)	.40 (.30)	15.7 (10.7)	1.3 (.32)
PhD. (n=22)	3.0 (5.0)	4.9 (5.6)	2.8 (4.2)	1.6 (2.0)	2.0 (2.1)	.27 (.34)	1.4 (10.5)	1.1 (.21)
Current Clinical Supervision [p, (NS, if p>.05)]	NS	NS	NS	NS	NS	NS	NS	.027
Yes (n=135)	4.7 (4.5)	7.8 (6.1)	4.9 (4.7)	2.3 (2.4)	3.2 (3.0)	.43 (.34)	16.2 (10.8)	1.3 (.31)
No (n=110)	4.9 (5.1)	8.1 (7.2)	4.5 (5.2)	3.0 (2.9)	3.5 (3.4)	.45 (.39)	15.5 (10.2)	1.4 (.41)

3.2.2. Intercorrelations between BSI Scores and Some Continuous Variables

Intercorrelations between BSI scores and certain continuous variables were investigated with Pearson correlation. These variables are: age, years of clinical experience, total hours of training, monthly hours of clinical supervision (total hours of supervision the professional receives in a month), total hours of supervision, and total hours of personal therapy (total hours of personal therapy that the participant have experienced, considering his/her longest therapy experience) and the amount of weight one gives to different theoretical orientations (see Table 8).

A Pearson correlation addressed the relationship between Anxiety subscale score and age. The correlation was found to be statistically significant at an alpha level of .05, r (239) = -.173, $p < .01$, indicating that as age increases, anxiety score decreases. Anxiety subscale score was also significantly correlated to total years of clinical experience at an alpha level of .05, r (239) = -.200, $p < .05$, meaning that anxiety decreases as one’s clinical experience increases.

The relationship between Depression subscale score and age was investigated with Pearson correlation. The correlation was found to be statistically significant at an alpha level of .05, r (242) = -.201, $p < .01$, indicating that the two variables are negatively related. Similarly, there was a negative significant correlation between Depression subscale score and years of clinical experience at an alpha level of .05, r (242) = -.223, $p < .01$. There was also a significant correlation between weight of psychoanalytic theoretical orientation and Depression score at an alpha level of .05, r (242)

= .136, $p < .05$, indicating that as the weight of psychoanalytic orientation increases, depression increases.

Negative self subscale score was significantly negatively correlated to age at an alpha level of .05, r (241) = .182, $p < .01$, indicating that the two variables are negatively related. Negative self was also significantly negatively correlated to years of clinical experience at an alpha level of .05, r (241) = -.229, $p < .01$. There was also a significant correlation between Negative self and weight of psychoanalytic orientation at an alpha level of .05, r (241) = .147, $p < .05$, meaning that the two variables are positively related.

Somatization score was significantly correlated to years of clinical experience at an alpha level of .05, r (241) = -.130, $p < .05$. That is, Somatization decreases as years of clinical experience increases.

Hostility Index score was significantly negatively correlated with both age and years of clinical experience at an alpha level of .05, (p (240) = -.203 and -.243, respectively), $p < .05$. It was also significantly negatively correlated to total hours of supervision and total hours of personal psychotherapy at an alpha level of .05, (r (240) = -.143 and -.133, respectively), $p < .05$. These findings point to a negative relationship between hostility and these variables.

A Pearson correlation analysis found a significant correlation between Global Severity Index score and age and years of clinical experience at an alpha level of .05 (r (237) = -.203 and -.243, respectively), $p < .05$, indicating that these two variables are negatively related to Global

Severity Index score. In addition, there a significant positive correlation was found between Global Severity Index and weight of psychoanalytic theoretical orientation at an alpha level of .05, r (237) = .137, $p < .05$, meaning that as the Global Severity Index score increases as weight of psychoanalytic orientation increases.

Positive Symptom Total was significantly negatively correlated to age and years of clinical experience at an alpha level of .05, (r (237) = -.173 and -.198, respectively), $p < .01$. It was also positively correlated to weight of psychoanalytic theoretical orientation at an alpha level of .05, r (237) = .137, $p < .05$.

Positive Symptom Distress Index was found to be significantly negatively correlated to age, years of clinical experience, total hours of training, and total hours of personal therapy at an alpha level of .05 (r (230) = -.263, -.280, -.207, -.177, respectively), $p < .01$. It was also significantly negatively correlated to monthly hours of received supervision (r (230) = -.147, $p < .05$) and total hours of received supervision (r (230) = -.155, $p < .05$) at an alpha level of .05.

Table 8. Intercorrelations between BSI Subscale Scores and Some Continuous Variables

	Mean BSI Subscale Scores					Index Scores		
	Anxiety	Depression	Negative Self	Somatization	Hostility	Global Severity Index	Positive Symptom Total	Positive Symptom Distress Index
Age	-.173**	-.201**	-.182**	-.020	-.187**	-.203**	-.173**	-.263**
Years of Clinical Experience	-.200**	-.223**	-.229**	-.130*	-.206**	-.243**	-.198**	-.280**
Total Hours of Training	-.113	-.088	-.103	-.047	-.122	-.126	-.088	-.207**
Monthly Hours of Supervision	-.003	-.006	.045	-.094	-.016	-.007	.061	-.147*
Total Hours of Supervision	-.081	-.079	-.082	-.057	-.143*	-.097	-.077	-.155*
Total Hours of Therapy	-.095	-.122	-.053	-.086	-.133*	-.105	-.068	-.177**
Weight of Theoretical Orientation								
Biological Psychiatry	.040	.025	.040	-.029	.123	.030	.028	-.034
Psychoanalytic	.070	.136*	.147*	.079	.089	.133*	.137*	.023
Existential-Humanistic	-.043	.011	.013	.056	.000	.004	-.026	-.008
Cognitive-Behavioral	-.007	-.004	.035	.030	.022	.018	-.042	.034
Others	.046	.081	.098	.062	.038	.080	.013	.092

* p< .05, ** p< .01

3.3. Attachment Styles among Mental Health Professionals in Turkey

Table 9 shows the frequency of four attachment categories as well as mean RSQ subscale scores for each attachment style. Overall, 87.1 % of the sample fell into secure attachment category, 7.1 % fell into dismissing attachment category, 4.2 % fell into preoccupied attachment category, and 1.7 % fell into fearful attachment category. There was no difference between the six professional groups in terms of the number of their members in each attachment category.

Between-group differences with respect to subscale RSQ scores were analyzed with one-way analysis of variance. The only statistically significant difference was found for Dismissing subscale score at an alpha level of .05, F (5, 236) = 3.34, $p < .01$. A Tukey HSD test indicated that the mean of professionals in the “Others” category was significantly higher than mean scores of psychiatrists and clinical psychologists in terms of their Dismissing attachment scores.

Table 9. Attachment Style based on Relationship Scales Questionnaire (RSQ)

	Total (n=245)	1 Psychologists (n=92)	2 Psychiatrists (n=31)	3 Psych. Counselors (n=29)	4 Clinical Psych (n=51)	5 Cli.Psy. M.A. st. (n=29)	6 Others (n=13)	p (NS, if p>.05)
Attachment Category (%)								NS
Secure	87.1	84.6	90.0	89.3	94.0	79.3	83.3	
Preoccupied	4.2	4.4	3.3	3.6	4.0	6.9	---	
Dismissing	7.1	9.9	6.7	7.1	---	6.9	16.7	
Fearful	1.7	1.1	---	---	2.0	6.9	---	
Mean RSQ Subscale Scores (SD)								
Secure	5.1 (0.9)	4.9 (0.8)	5.0 (1.0)	5.4 (0.9)	5.2 (0.8)	5.0 (0.7)	5.2 (1.0)	NS
Preoccupied	3.4 (0.7)	3.5 (0.8)	3.2 (0.5)	3.4 (0.8)	3.4 (0.7)	3.5 (0.7)	3.6 (0.5)	NS
Dismissing	3.3 (0.8)	3.3 (0.8)	3.0 (0.8)	3.5 (0.9)	3.1 (0.7)	3.4 (0.9)	3.9 (1.1)	.006 (2=4<6)
Fearful	2.3 (1.0)	2.4 (1.0)	2.1 (0.8)	2.2 (1.1)	2.2 (0.9)	2.6 (1.0)	2.5 (1.0)	NS

Groups:

1: Those who have a B.A. or M.A. degree other than clinical psychology in psychology
2: Psychiatry interns and residents
3: Those who have a B.A. degree in Guidance and psychological Counseling
4: Those who have clinical psychology M.A. degree
5: Clinical psychology M.A. students.
6: Others (eg. Social workers, nurses etc.)

A one-sample t-test using an alpha level of .05 compared the sample RSQ subscale means with means of Sümer and Güngör's (1999) study. There was a statistically significant difference between the two samples in terms of secure, preoccupied, dismissing, and fearful attachment subscale scores (t (241) = 10.62, -17.32, -14.81, -16.64, respectively), $p < .001$. A chi-square test was also applied to compare between group differences in terms of the frequencies of participants falling into each attachment group. This test was found to be statistically significant at an alpha level of .05, χ^2 (3, N = 242) = 189.74, $p < .01$. The observed frequencies for the four categories can be found in Table 10.

Table 10. Comparison of RSQ scores with Sümer & Güngör's (1999) study

	Groups		
Mean RSQ Subscale Scores (SD)	**1 Our sample (n=242)**	**2 Sümer & Güngör (1999) (n=301)**	**p** (NS, if p>.05)
Secure	5.1 (.86)	4.5 (1.0)	.000
Preoccupied	3.4 (.71)	4.2 (1.0)	.000
Dismissing	3.3 (.83)	4.1 (0.9)	.000
Fearful	2.3 (.98)	3.4 (1.2)	.000
Attachment Category (%)			
Secure	87.1	43.2	.000
Preoccupied	4.2	28.2	
Dismissing	7.1	19.3	
Fearful	1.7	9.3	

In order to compare attachment styles of the sample with participants with similar professional background, the results of a study by Ligiéro and Gelso's (2002) study on clinical and counseling psychologists. Since the authors reported the percentage of participants with a mean score above 4

on each RSQ subscale, the frequency of the participants in our sample who scored above 4 on each RSQ subscale was calculated. Then the frequencies of the two groups were compared with chi-square test. This test was found to be statistically significant for preoccupied and fearful RSQ scores at an alpha level of .05 (χ^2 (3, N = 242) = 10.07 and χ^2 (3, N = 242) = 57.43, respectively), $p < .01$. The frequency of participants with a mean score of 4 or higher on Preoccupied and Fearful RSQ subscales in Ligiéro and Gelso's (1999) study was significantly higher than those in our study. Table 11 shows the observed frequencies of the two groups.

Table 11.Comparison with Ligiéro & Gelso (2002) study in terms of Attachment Styles as measured by RSQ

	Groups		
Percentage of therapists rated themselves as above 4 on the following subscales (%)	**1 Our sample (n=242)**	**2 Ligiéro & Gelso (2002) (n=50)**	**p** (NS, if p>.05)
Secure	87.2	90.0	NS
Preoccupied	15.3	24.0	.002
Dismissing	15.7	18.0	NS
Fearful	5.4	27.0	.000

3.3.1. The Relationship between Attachment Style and Psychiatric Symptomatology

In order to investigate the relationship between attachment style and psychiatric symptomatology, BSI subscale scores of participants with secure and insecure attachment styles (as determined by their RSQ score) were compared with independent samples t-test. Since the number of participants in three insecure attachment categories were rather small (there were 10 people in preoccupied attachment category, 17 people in dismissing

attachment category, and 4 people in fearful attachment category.), these three groups were combined under the heading of “insecure attachment” category.

Table 12 shows the results of between group comparisons. All tests were statistically significant at an alpha level of .05. With respect to five BSI subscale scores-Anxiety, Depression, Negative Self, Somatization, and Hostility- participants with insecure attachment styles scored significantly higher than those with secure attachment style (t (236) = 7.23, t (238) = 7.88, t (237) = 7.67, t (237) = 4.29, t (235) = 7.23, respectively), $p < .001$. In addition, insecurely-attached participants scored also higher than securely-attached participants on Global Severity Index (t (233) = 8.65, $p < .001$), Positive Symptom Total (t (233) = 7.08, $p < .001$), and Positive Symptom Distress Index (t (226) = 6.30, $p < .001$).

Table 12. The Relationship between Attachment Style and Psychiatric Symptomatology

	Attachment Style		
Mean BSI Subscale Scores (SD)	**1 Secure (n=209)**	**2 Insecure (n=31)**	**p** (NS, if p>.05)
Anxiety	4.0 (4.0)	9.9 (5.7)	.000
Depression	6.7 (5.7)	15.9 (8.2)	.000
Negative Self	3.8 (4.1)	10.3 (6.1)	.000
Somatization	2.3 (2.3)	4.3 (3.2)	.000
Hostility	2.8 (2.6)	6.8 (4.5)	.000
Index Scores			
Global Severity Index	.37 (.30)	.89 (.41)	.000
Positive Symptom Total	14.1 (9.5)	26.9 (9.1)	.000
Positive Symptom Distress Index	1.3 (.32)	1.7 (.39)	.000

3.4. Burnout Profiles of Mental Health Professionals in Turkey

Table 13 shows mean Maslach Burnout Scale subscale scores of the overall sample and each of the six professional groups. Note that unlike other MBI subscale scores, higher scores on Personal Accomplishment subscale indicate lower personal accomplishment. When the means of the overall subscale is compared to cut-off burnout scores established by Çam (1992), it was found that, overall, mental health professionals in this sample are not experiencing emotional exhaustion or depersonalization and they also have a high sense of personal accomplishment. That is, our overall sample does not seem to suffer from burnout.

A one-way analysis of variance was used to compare six professional groups in terms of their MBI subscale scores at an alpha level of .05. The only significant result was found for Personal Accomplishment subscale score, F (5, 235) = 3.06, $p < .05$. A Tukey HSD test revealed that the mean for psychiatrists was significantly higher than the mean for psychological counselors, indicating that psychiatrists have a lower sense of personal accomplishment compared to psychological counselors.

Table 13. Burnout Profiles based on Maslach Burnout Inventory (MBI)

Mean MBI Subscale Scores (SD)	Total (n=245)	Groups: 1 Psychologists (n=92)	2 Psychiatrists (n=31)	3 Psych. Counselors (n=29)	4 Clinical Psych (n=51)	5 Cli.Psy. M.A. st. (n=29)	6 Others (n=13)	P (NS, if p>.05)
Emotional Exhaustion	9.8 (5.9)	10.3 (6.5)	10.2 (5.0)	9.3 (6.2)	9.5 (5.8)	8.7 (4.3)	9.5 (6.9)	NS
Depersonalization	2.9 (3.0)	3.2 (3.2)	3.1 (2.8)	3.0 (3.9)	2.0 (2.7)	3.0 (2.2)	2.4 (2.9)	NS
Personal Accomplishment[1]	10 (4.1)	9.7 (4.1)	12.1 (5.0)	9.0 (3.5)	9.5 (3.6)	11.2 (4.0)	8.6 (3.2)	.011 (3<2)

[1] *Unlike other MBI subscale scores, a higher score on Personal Accomplishment subscale indicates lower personal accomplishment.*

Groups:
1: Those who have a B.A. or M.A. degree other than clinical psychology in psychology
2: Psychiatry interns and residents
3: Those who have a B.A. degree in Guidance and psychological Counseling
4: Those who have clinical psychology M.A. degree
5: Clinical psychology M.A. students.
6: Others (eg. Social workers, nurses etc.)

3.4.1. The Relationship of MBI Subscale Scores with some Categorical Variables

The relationship of MBI subscale scores with categorical variables was investigated. These variables are: gender, marital status, university degree, and current clinical supervision (whether the individual is currently receiving clinical supervision or not) (See Table 14).

An independent samples t-test compared males and females in terms of their MBI subscale results. The results showed that there are no statistically significant between group differences at an alpha level of .05, meaning that male and females seem to experience similar amounts of emotional exhaustion, depersonalization and personal accomplishment.

The only significant result with respect to marital status was found for Depersonalization subscale scores at an alpha level of .05, t (241) = 2.06, $p < .05$. Mean Depersonalization score of single participants was significantly higher than that of married or cohabiting participants.

A one-way analysis of variance compared mean MBI subscale scores of participants with B.A., M.A. or PhD degree as their highest education status was significant at an alpha level of .05 for Depersonalization score, F (2, 240) = 12.20, $p < .005$. A Tukey HSD test indicated, with respect to mean Depersonalization subscale scores, there was no significant difference between M.A. and PhD level professionals but their scores were significantly lower than B.A. level professionals.

Table 14. The Relationship of MBI Subscale Scores and Some Categorical Variables

Categorical Variables	**MBI Subscale Scores (SD)**		
	Emotional Exhaustion	Depersonalization	Personal Accomplishment[1]
Gender [p, (NS, if p>.05)]	NS	NS	NS
Male (n=50)	9.7 (5.4)	2.5 (2.5)	9.8 (4.3)
Female (n=193)	9.8 (6.1)	3.0 (3.2)	10.1 (4.0)
Marital status [p, (NS, if p>.05)]	NS	.041	NS
Single (n=143)	9.8 (6.1)	3.2 (3.1)	10.2 (3.8)
Married/cohabiting (n=102)	9.7 (5.7)	2.4 (2.9)	9.8 (4.5)
University Degree [p, (NS, if p>.05)]	NS	.001 (2=3<1)	NS
B.A. (n=120)	10.4 (6.3)	3.5 (3.1)	10.2 (4.2)
M.A. (n=101)	9.3 (5.6)	2.4 (2.9)	9.8 (3.5)
PhD. (n=22)	8.7 (5.4)	1.2 (1.7)	9.6 (5.7)
Current Clinical Supervision [p, (NS, if p>.05)]	NS	NS	NS
Yes (n=135)	9.6 (5.6)	2.6 (2.7)	10.5 (4.3)
No (n=110)	9.9 (6.2)	3.1 (3.3)	9.6 (3.8)

[1] *Unlike other MBI subscale scores, a higher score on Personal Accomplishment subscale indicates lower personal accomplishment.*

An independent samples t-test comparing MBI subscale scores of participants who are currently receiving clinical supervision to who are not did not yield to statistically significant results. In other words, there was no difference between participants receiving clinical supervision and who are not with respect to the three measures of burnout.

3.4.2. Intercorrelations between MBI Subscale Scores and Some Continuous Variables

Intercorrelations between MBI scores and certain continuous variables were investigated with Pearson correlation. These variables are: age, years of clinical experience, total hours of training, monthly hours of clinical supervision (total hours of supervision the professional receives in a month), total hours of supervision, and total hours of therapy (total hours of personal therapy that the participant have experienced, considering his/her longest therapy experience), and the amount of weight one gives to different theoretical orientations (see Table 15).

There was no statistically significant correlation between Emotional Exhaustion and any of these variables at an alpha level of .05. Mean Depersonalization subscale score was found to be significantly correlated to age (r (241) = -.215, $p < .01$) and years of clinical experience (r (241) = -.223, $p < .01$), indicating that these variables are negatively related to depersonalization. Depersonalization was also significantly correlated to total hours of personal therapy at an alpha level of .05, r (241) = -.141, $p < .05$, indicating that as the total number of psychotherapy one has received increases, depersonalization decreases.

Table 15. Intercorrelations between MBI Subscale Scores and Some Continuous Variables

	Mean MBI Subscale Scores		
	Emotional Exhaustion	Depersonalization	Personal Accomplishment[1]
Age	-.070	-.215**	-.184**
Years of Clinical Experience	-.048	-.223**	-.205**
Total Hours of Training	-.064	-.120	-.094
Monthly Hours of Supervision	-.001	-.010	.168**
Total Hours of Supervision	.059	-.068	-.079
Total Hours of Personal Therapy	-.023	-.141*	.095
Weight of Theoretical Orientation			
Biological Psychiatry	.031	.056	.162*
Psychoanalytic	-.004	-.003	.138*
Existential-Humanistic	-.066	-.093	-.078
Cognitive-Behavioral	.001	-.040	.468
Others	-.115	-.098	-.010

* p< .05, ** p< .01

[1] *Unlike other MBI subscale scores, a higher score on Personal Accomplishment subscale indicates lower personal accomplishment.*

Personal Accomplishment subscale was found to be significantly correlated with age, years of clinical experience, and monthly ours of received supervision at an alpha level of .05 (r (239) = -.184, -.205, and .168, respectively, p < .01). That is, sense of personal accomplishment increases as age and years of clinical experience increases whereas it decreases as monthly hours of supervision increases. With regard to weight of theoretical orientation, Personal accomplishment subscale score was significantly correlated to Biological Psychiatry (r (236) = .162, p < .05) and Psychoanalytic orientations (r (236) = .138, p < .05), indicating that one's sense of personal accomplishment decreases as he weights more on these two orientations.

3.4.3. The Relationship between Attachment Style and Burnout

In order to investigate the relationship between attachment style and burnout, a one-sample t-test was used to compare mean MBI subscale scores of participants with secure and insecure attachment styles. This test was found to be statistically significant at an alpha level of .05 for Emotional Exhaustion and Depersonalization subscales (*t* (237) = 3.34 and 2.16, respectively, *p* < .05), indicating that insecurely attached participants experience more emotional exhaustion and depersonalization than securely attached individuals. On the other hand, there was no statistically significant difference between the two groups in terms of their Personal Accomplishment scores (see Table 16).

Table 16. The Relationship between Attachment Style and Burnout

	Attachment Style		
Mean MBI Subscale Scores (SD)	**1 Secure (n=208)**	**2 Insecure (n=31)**	**p** (NS, if p>.05)
Emotional Exhaustion	9.2 (5.5)	12.9 (7.3)	.001
Depersonalization	2.6 (2.8)	3.8 (3.4)	.032
Personal Accomplishment[1]	9.9 (4.0)	10.8 (4.9)	NS

[1] *Unlike other MBI subscale scores, a higher score on Personal Accomplishment subscale indicates lower personal accomplishment.*

3.4.4. The Relationship between Psychiatric Symptomatology and Burnout

A series of Pearson correlations addressed the relationship between psychiatric symptomatology (as measured by BSI) and burnout (as measured by MBI). Table 17 shows the individual correlations between each BSI and MBI subscale.

Emotional Exhaustion subscale scores significantly correlated with all 8 BSI scores, namely Anxiety (r (240) = .358) , Depression (r (240) = .310), Negative Self (r (240) = .342), Somatization (r (240) = .226), Hostility (r (240) = .307), Global Severity Index (r (237) = .368), Positive Symptom Total (r (237) = .332), and Positive Symptom Distress Index (r (230) = .333) at an alpha level of .05, $p < .01$.

There was a statistically significant correlation between Depersonalization subscale score and all 8 BSI scores (Anxiety, Depression, Negative self, Somatization, Hostility, Global Severity Index, Positive Symptom Total, and Positive Symptom Distress Index) at an alpha level of .05 (r (240) = .367, r (240) = .328, r (240) = .362, r (240) = .255, r (240) = .364, r (237) = .389, r (237) = .372, and r (230) = .299, respectively), p <

.01. These findings suggest that depersonalization increases as these psychiatric symptoms increase.

Personal Accomplishment subscale score significantly correlated to Anxiety (r (240) = .211), Depression (r (240) = .299), Negative Self (r (240) = .309), Hostility (r (240) = .229), Global Severity Index (r (237) = .277), and Positive Symptom Total (r (237) = .265) at an alpha level of .05, $p <$ .05. Personal Accomplishment also significantly correlated to Positive Symptom Distress Index at an alpha level of .05, r (230) = .158, $p < .05$. These results suggest that one's sense of personal accomplishment decreases as these BSI symptoms increase.

Table 17. Intercorrelations between Burnout and Psychiatric Symptomatology

	MBI Subscales		
BSI Subscales	Emotional Exhaustion	Depersonalization	Personal Accomplishment[1]
Anxiety	.358**	.367**	.211**
Depression	.310**	.328**	.299**
Negative Self	.342**	.362**	.309**
Somatization	.226**	.255**	.046
Hostility	.307**	.364**	.229**
Index Scores			
Global Severity Index	.368**	.389**	.277**
Positive Symptom Total	.332**	.372**	.265**
Positive Symptom Distress Index	.333**	.299**	.158*

** p< .05, **p< .01*

[1] *Unlike other MBI subscale scores, a higher score on Personal Accomplishment subscale indicates lower personal accomplishment.*

3.5. Predictors of Psychiatric Symptoms

A series of stepwise multiple regression analyses were conducted in order to identify variables that predict BSI scores. The variables that were included in the analyses as predictors were: Age, gender, marital status, university degree (M.A. or PhD.), professional group (psychologist, psychiatrist, etc.), years of clinical experience, whether the individual is currently receiving supervision, monthly hours of supervision, total hours of supervision, total hours of training, total hours of one's personal therapy experience, weight of theoretical orientation (biological psychiatry, psychoanalytic, cognitive-behavioral, and existential-humanistic), RSQ subscale scores for each attachment category, and MBI subscale scores. MBI subscale scores were included due to their highly significant correlations between BSI scores (refer to Table 17), although it should be noted that it is not possible to infer a causal relationship between the two concepts. The entry criteria for probability F was selected as .08 and the removal criteria was selected as .12 in all analyses.

Table 18 illustrates multiple regression analysis for variables predicting Anxiety score. The major predictor of anxiety score was Fearful Attachment Score, which explained approximately 29 % of the overall variance. Emotional Exhaustion score, Preoccupied Attachment score, Secure Attachment score, and being a Psychological Counselor were also significant predictors of Anxiety score. Anxiety score increased as Fearful Attachment, Emotional Exhaustion, Preoccupied Attachment scores increased; it decreased as Secure Attachment Score increased. Being a

psychological counselor was also related to increased Anxiety scores. These variables together explained 34 % of the overall variance.

Table 18. Summary of Stepwise Multiple Regression Analysis for Variables Predicting Anxiety Score

Variables	B	SE B	ß	Δ R^2
Fearful Attachment Score	1.593	.374	.325	.286
Emotional Exhaustion	.140	.048	.172	.032
Preoccupied Attachment Score	1.214	.433	.180	.015
Secure Attachment Score	-.803	.386	-.143	.010
Being a Psychological Counselor	1.475	.822	.099	.010

Adj. R^2 *= .338 , (ps< .05)*

As can be seen in Table 19, variables that predict Depression score are, Fearful Attachment Score, Personal Accomplishment score, Preoccupied Attachment Score, gender, being in an "other" profession category, and the weight of psychoanalytic orientation. Fearful and Preoccupied Attachment scores, Personal Accomplishment score, being a female, and being more psychoanalytically oriented were positively correlated with depression whereas being in the "other" profession category was negatively correlated with depression. These variables accounted for 40 % of the overall variance in Depression score.

Table 19. Summary of Stepwise Multiple Regression Analysis for Variables Predicting Depression Score

Variables	B	SE B	ß	Δ R^2
Fearful Attachment Score	3.124	.412	.452	.336
Personal Accomplishment[1]	.290	.090	.174	.035
Preoccupied Attachment Score	1.688	.551	.177	.020
Gender *("0": Male, "1": Female)*	1.729	.896	.103	.011
Professional category-"Other"	-3.164	1.588	-.105	.009
Theoretical Orientation-Psychoanalytic	.010	.006	.095	.009

Adj. R^2 *= .404 , (ps< .05)*

[1] *Unlike other MBI subscale scores, a higher score on Personal Accomplishment subscale indicates lower personal accomplishment.*

With respect to Negative Self, Fearful Attachment score, Personal Accomplishment score, Secure Attachment score, Psychoanalytic orientation, and Emotional Exhaustion were found as significant predictors. Negative Self score increased as Secure Attachment score decreased and the other scores increased. These variables together explained 44 % of the variance in Negative Self score (see Table 20).

Table 20. Summary of Stepwise Multiple Regression Analysis for Variables Predicting Negative Self Score

Variables	B	SE B	ß	Δ R^2
Fearful Attachment Score	2.062	.357	.404	.378
Personal Accomplishment[1]	.175	.066	.142	.037
Preoccupied Attachment Score	1.230	.414	.175	.015
Secure Attachment Score	-.739	.375	-.126	.011
Theoretical Orientation-Psychoanalytic	.008	.004	.108	.011
Emotional Exhaustion	.085	.046	.100	.008

Adj. $R^2 = .444$ *,* $(ps < .05)$

[1] *Unlike other MBI subscale scores, a higher score on Personal Accomplishment subscale indicates lower personal accomplishment.*

The results of stepwise multiple regression analysis that investigated predictors of Hostility score found Fearful Attachment Score, Biological Psychiatry orientation, Depersonalization score, Marital status, and having an M.A. degree as significant predictors of hostility. Hostility was found to increase as Fearful Attachment and Depersonalization scores increased, as the person is more oriented towards biological psychiatry perspective, as the person is married; and it was found to decrease if the participant had an M.A. degree. These variables explained 35 % of the variance (see Table 21).

Table 21. Summary of Stepwise Multiple Regression Analysis for Variables Predicting Hostility Score

Variables	B	SE B	ß	Δ R^2
Fearful Attachment Score	1.673	.203	.510	.304
Theoretical Orientation-Biological Psychiatry	.034	.012	.160	.021
Depersonalization	.129	.066	.121	.015
Marital status *("0":Single, "1": Married/cohabiting)*	.772	.368	.118	.010
Having M.A. degree	-.697	.380	-.108	.010

Adj. R^2 *= .345 , (ps< .05)*

Table 22 illustrates the results of multiple regression analysis for variables predicting Global Severity Index score. These variables, which together account for 45 % of the variance, are Fearful Attachment score, Personal Accomplishment score, Emotional Exhaustion score, Preoccupied Attachment score, and Psychoanalytic orientation. GSI score increased as these scores increased.

Table 22. Summary of Stepwise Multiple Regression Analysis for Variables Predicting Global Severity Index Score

Variables	B	SE B	ß	Δ R^2
Fearful Attachment Score	.186	.022	.496	.401
Personal Accomplishment[1]	.012	.005	.127	.024
Emotional Exhaustion	.008	.003	.134	.017
Preoccupied Attachment Score	.072	.029	.139	.014
Theoretical Orientation-Psychoanalytic	.001	.000	.099	.009

Adj. R^2 *=.453 , (ps< .05)*

[1] *Unlike other MBI subscale scores, a higher score on Personal Accomplishment subscale indicates lower personal accomplishment.*

With respect to Positive Symptom Total score, Fearful Attachment Score, Personal Accomplishment score, Emotional Exhaustion score, and psychoanalytic orientation were revealed as significant predictors. These variables were all positively correlated with PST score. Overall, they were

found to explain 41 % of the variance in Positive Symptom Total score (see Table 23).

Table 23. Summary of Stepwise Multiple Regression Analysis for Variables Predicting Positive Symptom Total Score

Variables	B	SE B	ß	Δ R^2
Fearful Attachment Score	5.788	.597	.543	.375
Personal Accomplishment[1]	.310	.139	.120	.022
Emotional Exhaustion	.201	.099	.114	.010
Theoretical Orientation-Psychoanalytic	.015	.008	.093	.008

Adj. R^2*=.405 , (ps< .05)*

[1] *Unlike other MBI subscale scores, a higher score on Personal Accomplishment subscale indicates lower personal accomplishment.*

The results of stepwise multiple regression analysis identified Fearful Attachment score, Emotional Exhaustion score, years of clinical experience, monthly hours of supervision, and gender as significant predictors of Positive Symptom Distress Index. PSDI score increased as Fearful Attachment and Emotional Exhaustion scores increased; as years of clinical experience and monthly hours of supervision decreased. It was also higher when the participant is a female. These factors together explain 29 % of the overall variance (see Table 24).

Table 24. Summary of Stepwise Multiple Regression Analysis for Variables Predicting Positive Symptom Distress Index Score

Variables	B	SE B	ß	Δ R^2
Fearful Attachment Score	.117	.024	.308	.205
Emotional Exhaustion	.014	.004	.215	.034
Years of Clinical Experience	-.010	.003	-.184	.032
Monthly Hours of Supervision	-.012	.004	-.158	.022
Gender *("0": Male, "1": Female)*	.111	.054	.120	.014

Adj. R^2*= .291 , (ps< .05)*

3.6. Predictors of Burnout

A series of stepwise multiple regression analyses were conducted in order to identify variables that predict MBI scores. The variables that were included in the analyses as predictors were: Age, gender, marital status, university degree (M.A. or PhD.), professional group (psychologist, psychiatrist, etc.), years of clinical experience, whether the individual is currently getting supervision, monthly hours of supervision, total hours of supervision, total hours of training, total hours of one's personal therapy experience, weight of theoretical orientation (biological psychiatry, psychoanalytic, cognitive-behavioral, and existential-humanistic), RSQ subscale scores for each attachment category, and BSI subscale scores (Anxiety, Depression, Negative self, Somatization, and Hostility). BSI subscale scores were included due to their highly significant correlations between MBI scores (refer to Table 17), although it should be noted that it is not possible to infer a causal relationship between the two concepts. The entry criteria for probability F was set as .08 and the removal criteria was set as .12 in all analyses.

A stepwise multiple regression analysis indicated that Anxiety Index score, Fearful Attachment score, and total hours of supervision are significant predictors of Emotional Exhaustion. These variables were all positively correlated with Emotional Exhaustion score. They together explained 17 % of the variance in Emotional Exhaustion subscale score (see Table 25).

Table 25. Summary of Stepwise Multiple Regression Analysis for Variables Predicting Emotional Exhaustion

Variables	B	SE B	ß	Δ R^2
Anxiety Index	.289	.090	.234	.128
Fearful Attachment Score	1.503	.443	.249	.037
Total Hours of Supervision	.002	.001	.120	.014

Adj. $R^2 = .168$ *, (ps< .05)*

Table 26 illustrates the results of stepwise multiple regression analysis for factors predicting Depersonalization score. These variables, which accounted for 25 % of the variance, are Fearful Attachment Score, Anxiety Index score, Having M.A. degree, being psychiatry intern or resident, and Dismissing Attachment score. Depersonalization score increased as Fearful and Dismissing Attachment and Anxiety scores increased, when the person is a psychiatry intern or resident and when s/he did not have an M.A. degree.

Table 26. Summary of Stepwise Multiple Regression Analysis for Variables Predicting Depersonalization

Variables	B	SE B	ß	Δ R^2
Fearful Attachment Score	.799	.243	.259	.198
Anxiety Index	.108	.043	.171	.023
Having M.A. degree	-1.206	.383	-.200	.022
Being psychiatry intern/resident	1.310	.572	.144	.015
Dismissing Attachment Score	.478	.253	.132	.012

Adj. $R^2 = .253$ *, (ps< .05)*

With respect to Personal Accomplishment, Secure Attachment score, Dismissing Attachment score, Depression Index score, Being psychiatry intern or resident, age, and Fearful Attachment score were indicated as significant predictors. Secure and Dismissing Attachment scores and age were negatively correlated with Personal Accomplishment score whereas

the other variables were positively correlated with Personal Accomplishment score. Overall, these variables explain 30 % of the variance (See Table 27).

Table 27. Summary of Stepwise Multiple Regression Analysis for Variables Predicting Personal Accomplishment[1]

Variables	B	SE B	ß	Δ R^2
Secure Attachment Score	-.925	.324	-.195	.096
Dismissing Attachment Score	-2.002	.334	-.411	.087
Depression Index	.130	.042	.217	.074
Being psychiatry intern/resident	2.310	.724	.189	.021
Age	-.077	.031	-.154	.023
Fearful Attachment Score	.713	.367	.172	.012

Adj. $R^2 = .295$ *,* $(ps < .05)$

[1] *Unlike other MBI subscale scores, a higher score on Personal Accomplishment subscale indicates lower personal accomplishment.*

CHAPTER 4. DISCUSSION

4.1. Psychiatric Symptomatology

The first hypothesis of this study was that psychiatric symptom levels of mental health professionals would not differ from general population. The results of this study failed to support this hypothesis. With respect to all BSI scores, mental health professionals scored significantly lower than the normal comparison group. The literature on this topic is basically divided into two different findings; some did not find a significant difference between mental health professionals and other comparison groups in terms of their psychiatric symptomatology (eg. Bozdoğan, 2007; Moldovan, 2006) whereas others revealed that mental health professionals are more likely to experience certain psychiatric problems such as depression (eg. Deutsch, 1985). However, there are also findings suggesting that, in general, mental health professionals are psychologically healthy (eg. Thoreson et al., 1989). The findings of this study, therefore, need further investigation and replication. One reason for this result might be that those professionals who are experienced psychological difficulties might not have filled in the survey in the first place, since participating in the study was based on volunteerism and self-report measures.

There was a significant gender difference within our sample in terms of their psychiatric symptom levels. Females scored higher than males on all BSI subscales except for Hostility. This is a typical finding that is found across different cultural and professional groups (eg. Culbertson, 1997; Deutsch, 1985; Reich, 1986). With respect to mental health professionals,

however, these findings should be interpreted with caution. Thoreson et al. (1989) argue that it would be inaccurate to argue that female mental health professionals are psychologically more distressed than males. The authors further argue that we should bear in mind the fact that women are more likely to disclose their problems than men in many cultures when interpreting this kind of findings. It should also be noted that higher scores of female participants are still within the normal limits.

There was also a significant effect of university degree on Depression, Hostility, Global Severity Index, and Positive Symptom Distress Index scores. In particular, participants with a Ph.D. degree scored significantly lower than participants with B.A. degree on these subscales. In a similar study, Deutsch (1985) also found a decreased amount of psychopathology among PhD-level therapists. This difference might be related to factors inherent in PhD-level education such as extended amount of clinical supervision and personal therapy. It is also possible that professionals suffering from psychological problems choose not to receive higher education. Nevertheless, further research is warranted in order to understand and explain the effect of education on psychiatric symptomatology among mental health professionals.

Psychiatric symptomatology seems to decrease as age and clinical experience increase. It seems that these factors act as a buffer against psychological distress. Another interesting finding is that, in general, one's level of psychiatric distress increases as he/she gives more weight to psychoanalytic theoretical orientation. One might argue that since

psychoanalytic schools give more weight to insight and personal awareness than other theories, these professionals might be more sensitive to and acknowledging of their own personal problems. It should be noted, however, that this is a relatively new finding which is not supported by previous research. Further research on this matter is warranted before reaching any conclusions.

4.2. Attachment Style

In this study, almost nine tenth of the sample (87.1 %) fell into secure attachment category, 7.1 % fell into dismissing attachment category, 4.2 % fell into preoccupied attachment category, and 1.7 % fell into fearful attachment category. The frequency of secure attachment in this sample was significantly higher and the frequencies of all three insecure attachment styles were significantly lower than the normal comparison group. These findings, therefore, support the second hypothesis that mental health professionals will display a higher frequency of secure attachment together with a lower frequency of insecure attachment compared to general population.

Attachment styles of our sample was compared with a study by Ligiéro and Gelso (1999) which investigated attachment styles of M.A. or PhD. level trainee therapists. Our sample was found to be less preoccupied and less fearful. Unfortunately, there is no any other such a cross-cultural comparison study that will allow us to make inferences about this finding. Nevertheless, this finding might stimulate further analysis of cross cultural comparisons in terms of attachment styles of mental health professionals.

There was a statistically significant relationship between attachment style (secure versus insecure) and all BSI scores, confirming the third hypothesis that securely attached professionals are expected to display less amount of psychiatric symptomatology than insecurely attached professionals. This finding is line with the widely established fact that securely attached individuals are psychologically healthier than insecurely attached individuals (Hazan & Shaver, 1990; Priel & Shamai, 1995).

4.3. Burnout

The analysis of MBI results showed that mental health professionals in this sample are not experiencing emotional exhaustion or depersonalization and they also have a high sense of personal accomplishment. That is, contrary to our fourth hypothesis, our overall sample does not seem to suffer from burnout. The only between group difference in terms of MBI subscales was found for Personal Accomplishment. Psychiatrists had significantly lower sense of personal accomplishment than psychological counselors. Although this finding is insufficient for a conclusive argument; one reason for this difference might be due to the nature of psychiatry education in Turkey. Here, psychiatry internship is characterized by a strong master-apprentice relationship which might in turn diminish the trainee's self-esteem and sense of personal accomplishment. Additionally, higher work loads of the psychiatrists especially at the hospitals might be a regarded as a factor compromising their sense of personal accomplishment. Psychiatrists (especially interns) in Turkey have to deal with a high amount of case load. In fact, in some of the

state institutions they have to see more than 50 patients a day, being able to spare only 10 minutes per patient.

Emotional exhaustion and depersonalization were found to be significantly related to attachment style (secure versus insecure). Securely attached mental health professionals seem to experience less emotional exhaustion and depersonalization than insecurely attached professionals. No significant relationship was found for personal accomplishment on the secure vs. insecure comparison. However, when the attachment style scores are treated as continuous variables in multiple regression analysis, it was found that personal accomplishment was predicted by the secure and dismissing attachment scores positively, and by the fearful attachment score negatively. This is an interesting result warrants further research. The self-report nature of this study does not allow us to distinguish whether higher personal accomplishment among more dismissingly-attached participants represent a "real" sense of personal accomplishment or it is for instance a narcissistic defense towards maintaining self-esteem. Overall, the fifth hypothesis of this study is mostly supported, only with a caveat about the role of dismissing attachment style on personal accomplishment.

Statistically significant correlations were found between BSI and MBI scores, supporting the sixth hypothesis that there would be significant positive correlations between psychiatric symptomatology and emotional exhaustion and depersonalization, together with a significant negative correlation between psychiatric symptomatology and and personal accomplishment. It should be noted, however, that causality cannot be

inferred from these results. That is, although burnout and psychiatric symptomatology are strongly related, it is not possible to identify which of them causes the other. Longitudinal studies warranted in order to identify the direction of causality between burnout and psychiatric problems.

4.4 Multiple Regression Analyses for Predicting BSI and MBI scores

In terms of BSI scores, the strongest predictor has been found to be attachment style. Psychiatric symptom level tends to decrease as one scores higher on secure attachment subscale and it tends to increase as one scores higher on insecure attachment (preoccupied, dismissing, fearful) attachment subscale of RSQ. This finding is in line with the literature suggesting that attachment patterns have an effect on psychological well being (eg. Hazan & Shaver, 1990; Priel & Shamai, 1995). In this study, fearful attachment score has particularly been the strongest predictor of psychiatric symptomatology as measured by BSI. Fearfully attachment style is characterized by a negative sense of self and expectancy that others would be unresponsive and rejecting. People with fearful attachment style fear and avoid close relationships since they expect these relationships to be harmful to them. Even though they avoid others, however, fearfully-attached individuals are highly dependent on others to maintain a positive sense of self. This tension between the need to depend on others and the fear that others will be harmful is by itself a source of anxiety and distress (Bartholomew & Horowitz, 1991).

Another important predictor of BSI scores has been burnout as measured by MBI. All three concepts of MBI (emotional exhaustion,

depersonalization, and personal accomplishment) have been related to BSI scores. In particular, psychiatric symptom level seems to increase as emotional exhaustion and depersonalization increase and it decreases as personal accomplishment increases. Previous studies in this field also suggest that psychiatric problems are related to burnout (eg. Peterson et al., 2008; Evans et al., 2006). Once again it should be noted that causality cannot be inferred between this two concepts.

An interesting finding with respect to multiple regression analysis for BSI scores was that four of these scores (Depression, Negative Self, Global Severity Index, and Positive Symptom Total) tended to increase as the professional's practice is more psychoanalytically oriented. It might be speculated that this finding is due to the certain factors inherent in psychoanalytical psychotherapy training, such as putting more weight on insight and identification and expression of personal conflicts. Nevertheless, this finding clearly needs replication before making serious inferences.

In terms of multiple regression analyses for predicting MBI subscale scores, attachment style was again found to be an important predictor of burnout. In particular, secure attachment relates to an increase the person's sense of personal accomplishment; whereas fearful attachment relates to an increase emotional exhaustion and depersonalization, whereas it relates to a decrease in personal accomplishment; and dismissing attachment relates to an increase in depersonalization and personal accomplishment. In general, these findings are parallel to previous research suggesting that secure

attachment is related to a decrease in burnout whereas insecure attachment is related to an increase in burnout.

Anxiety and depression, as measured by BSI, are found as predictors of burnout. Specifically, higher anxiety has been related to increased emotional exhaustion and depersonalization and depression was found to be related to a decrease in personal accomplishment. Once again, these findings suggest a strong relationship between psychiatric problems and burnout although a causal relationship between these two variables cannot be drawn in this particular study.

Being a psychiatry intern or resident seems to increase the level of depersonalization and to reduce personal accomplishment. As discussed before, reduced personal accomplishment for psychiatrists can be attributed to the nature of psychiatry education in Turkey, which is characterized by a strong master-apprentice relationship. It is also possible to attribute the increase in depersonalization among psychiatrists to their work conditions, especially in terms of their case load. For these professionals, depersonalization might be a way to deal with this case load and high emotional distress that it brings.

An interesting finding was found with respect to the relationship between clinical supervision and burnout. A positive correlation was found between total hours of clinical supervision and emotional exhaustion. Edwards et al. (2006) and Hyrkäs (2005) argue that the supervisee’s evaluation of the efficacy of supervision should be taken into account rather than objective measures such as total hours of supervision. Hyrkäs (2005)

further argues that ineffective supervision might even be detrimental to the professional, leading to problems such as job dissatisfaction. Therefore, it is possible that the self-rated efficacy of supervision would provide with a better understanding of the relationship between supervision and burnout instead of total hours per se.

4.5. Limitations and Implications for Further Research

There are certain limitations of this study which should be taken into account while interpreting the results. First of all, participation in this study was based on volunteerism rather than random selection, which may put doubt on the representativeness of the sample. Therefore, it is possible to speculate that those who did not fill in the survey might have rather different characteristics than those who did. It is rather important for further studies to develop necessary strategies and measures to reach professionals who did not participate in this study in order to have a broader understanding of the characteristics of mental health professionals in Turkey. Instead of survey method, more systematic strategies such as clinical interviews might help the researchers to reach a wider and more heterogeneous population.

There is another sample-related limitation concerning the age profile of the sample. More than 75 % of the sample was 30 years old and younger. One could again argue that low rates of burnout and psychopathology might be due to the fact that the majority of the sample consists of young professionals who are very enthusiastic about their jobs and who have not faced the “unpleasant” sides of the profession. Although certain characteristics of the sample might pose a difficulty in terms of generalizing

the findings, the numerical size of the sample was big enough to allow for tentative conclusions.

Another limitation is the use of correlational analyses for identifying the relationship between a large number of variables. Therefore caution must be taken while interpreting these results, since correlational studies only give us an idea about the relationship between variables rather than indicating causality.

It is also important to note that this study is based on self report technique and it was not possible to objectively verify participants' responses. It is therefore essential for future studies to replicate the findings of this study with more objective methods.

This study might suggest certain policy implications for preventing psychological problems and burnout among mental health professionals in Turkey. The higher rates of depersonalization and lower personal accomplishment among psychiatrists, for instance, suggest that certain policies should be implemented towards reducing case load of professionals (especially psychiatrists) working in public health care settings. In addition, it is necessary for mental health care institutions to provide necessary supervision and counseling services to mental health workers.

Despite its limitations, this study provides with a comprehensive profile in terms of psychological profiles of mental health professionals in Turkey. Further studies should try to deepen our understanding of mental health professionals in Turkey which should in turn stimulate support and intervention programs at both individual and organizational levels.

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CHAPTER 6. APPENDICES

Appendix A

ARAŞTIRMA ANKETİ: TÜRKİYE'DEKİ RUH SAĞLIĞI ÇALIŞANLARININ PROFESYONEL VE PSİKO-SOSYAL PROFİLLERİ

Lütfen bu araştırma anketine internet üzerinden KATILMAMIŞ iseniz devam ediniz.

Bu araştırmanın amacı Türkiye'deki ruh sağlığı çalışanlarının (psikolog, psikiyatr, psikolojik danışman, sosyal hizmet uzmanı vb.) profesyonel ve psikososyal profillerini tanımlamaya yöneliktir. Ülkemizde bu tarz kapsamlı bir profil çalışması bulunmamaktadır. Bu araştırmayla ruh sağlığı mesleklerinin her biri ve bütünü için değerli veriler elde etmeyi ve bu verileri bilimsel eser formatında meslek camialarımızla paylaşmayı hedefliyoruz. Meslek dallarımızın ihtiyaçlarını ve ülkemizin ruh sağlığı politikalarını tartışırken bu tür verilere çok ihtiyacımız olduğunu düşünüyoruz. O yüzden bu ankete Türkiye'de ruh sağlığı alanında çalışan bütün meslek erbabı davetlidir. Katılımınızla bu araştırmada mesleğinizin temsili niteliğini arttırmış olacaksınız.

Cevaplayacağınız anket her biri farklı özellikleri ölçen 5 ayrı modülden oluşmaktadır. Anketin tamamlanma süresi 30 ile 45 dk. arasında değişmektedir.

Bu çalışmaya katılmak tamamen gönüllülük esasına bağlıdır. Katılımcıların kimlik bilgileri ve bireysel cevapları kesinlikle saklı tutulacaktır. Anketteki soruların doğru ya da yanlış cevabı yoktur. Lütfen kendinize en yakın gelen, kendiniz için en uygun olduğunu düşündüğünüz cevabı yazınız ya da işaretleyiniz.

İlginiz ve desteğiniz için şimdiden teşekkür ederiz.

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1) Yukarıda belirtilen şartlar çerçevesinde bu çalışmaya katılmayı

□ Kabul ediyorum. □ Kabul etmiyorum.

2) Aktif olarak ruh sağlığı alanında çalışıyor musunuz?

□ Evet □ Hayır

Modül 1: Sosyo-demografik özellikler

3) Yaşınız: ________

4) Cinsiyetiniz:
□ Kadın □ Erkek

5) Medeniz durumunuz:
□ Bekar □ Evli □ Birlikte yaşıyor

6) Daha önce boşandıysanız, kaç kez: ________

7) Kaç çocuğunuz var: _______

8) Doğduğunuz yer:
□ Köy □Bucak □ İlçe merkezi □İl merkezi □ Büyükşehir

9) Yaşadığınız il neresidir: _____________

10) Yaşadığınız yer neresidir:
□ İl merkezi □ İlçe merkezi □ Bucak □ Kırsal kesim

Modül 2: Eğitim

11) Herhangi bir üniversite mezuniyet dereceniz var mı?
□ Evet □ Hayır

12) Aşağıdaki lisans derecelerinden hangisine/hangilerine sahip olduğunuzu ve bu dereceleri yurt içinde mi, yurt dışında mı aldığınızı lütfen işaretleyiniz.

	Evet	**Yurt içinde**	**Yurt dışında**
4 yıllık Psikoloji lisans			
6 yıllık Tıp Fakültesi			
4 yıllık PDR lisans			
4 yıllık Pedagoji lisans			
4 yıllık Sosyal Hizmet lisans			

4 yıllık Okul Öncesi Öğretmenliği lisans			
4 yıllık Hemşirelik Lisans			
4 yıllık herhangi bir lisans (___________)			

13) Yukarıda işaretlemiş olduğunuz lisans diploma(ları)nızı hangi yılda aldığınızı lütfen belirtiniz.aldığınızı lütfen belirtiniz.

Lisans Derecesi	**Mezuniyet Yılı**
4 yıllık Psikoloji lisans	
6 yıllık Tıp Fakültesi	
4 yıllık PDR lisans	
4 yıllık pedagoji lisans	
4 yıllık Sosyal Hizmet Lisans	
4 yıllık Okul Öncesi Öğretmenliği Lisans	
4 yıllık Hemşirelik Lisans	
4 yıllık herhangi bir lisans (____________)	

14) Aşağıdaki yüksek lisans derecelerinden sahip olduğunuzu/olduklarınızı lütfen işaretleyiniz.

	Evet	**Eğitimim devam ediyor**	**Yurt içinde**	**Yurt dışında**
Klinik Psikoloji YL				
Nöropsikoloji YL				
Sağlık Psikolojisi YL				
Başka bir Psikoloji alanında YL				
PDR YL				
Adli Tıp YL				
Okul Öncesi Öğretmenliği YL				
Pedagoji YL				
Sosyal Hizmet YL				
Psikiyatri Hemşireliği YL				
Diğer YL (_________)				

15) Yukarıda işaretlemiş olduğunuz yüksek lisans diploma(ları)nızı hangi yılda aldığınızı lütfen belirtiniz.

Yüksek Lisans Derecesi	Mezuniyet Yılı
Klinik Psikoloji YL	
Nöropsikoloji YL	
Sağlık Psikolojisi YL	
Başka bir Psikoloji alanında YL	
PDR YL	
Adli Tıp YL	
Okul Öncesi Öğretmenliği YL	
Pedagoji YL	
Sosyal Hizmet YL	
Psikiyatri Hemşireliği YL	
Diğer YL (___________)	

16) Aşağıdaki doktora veya uzmanlık derecelerinden sahip olduğunuzu/olduklarınızı lütfen işaretleyiniz.

	Evet	**Eğitimim devam ediyor**	**Yurt içinde**	**Yurt dışında**
Nöropsikiyatri Uzmanlığı				
Yetişkin Psikiyatrisi Uzmanlığı				
Çocuk Psikiyatrisi Uzmanlığı				
Başka bir tıp alanında uzmanlık				
Klinik Psikoloji Doktora (Ph.D)				
Klinik Psikoloji Doktora (Psy.D)				
Çocuk Klinik Psikoloji Doktora (Ph.D)				
Çocuk Klinik Psikoloji Doktora (Psy.D)				
Nöropsikoloji Doktora (Ph.D)				
Sağlık Psikolojisi Doktora (Ph.D)				
PDR Doktora (Ph.D)				
Adli Tıp Doktora (Ph.D)				
Pedagoji Doktora (Ph.D)				
Sosyal Hizmet alanında doktora (Ph.D)				
Başka bir Psikoloji alanında doktora (Ph.D)				
Psikiyatri Hemşireliği Doktora (Ph.D)				
Diğer Ph.D (__________)				
Klinik Psikoloji Post-doc (doktora sonrası eğitimi)				
Diğer Post-doc				

17) Yukarıda işaretlemiş olduğunuz doktora veya uzmanlık diploma(lar)ınızı hangi yılda aldığınızı lütfen belirtiniz.

Doktora Derecesi	**Mezuniyet Yılı**
Nöropsikiyatri Uzmanlığı	
Yetişkin Psikiyatrisi Uzmanlığı	
Çocuk Psikiyatrisi Uzmanlığı	
Başka bir tıp alanında Uzmanlık	
Klinik Psikoloji Doktora (Ph.D)	
Klinik Psikoloji Doktora (Psy.D)	
Çocuk Klinik Psikoloji Doktora (Ph.D)	
Çocuk Klinik Psikoloji Doktora (Psy. D)	
Nöropsikoloji Doktora (Ph. D)	
Sağlık Psikolojisi Doktora (Ph. D)	
PDR Doktora (Ph. D)	
Adli Tıp Doktora (Ph. D)	
Pedagoji Doktora (Ph. D)	
Sosyal Hizmet alanında Doktora (Ph. D)	
Başka bir Psikoloji alanında Doktora (Ph. D)	
Psikiyatri Hemşireliği Doktora (Ph. D)	
Diğer Ph. D (_______)	
Klinik Psikoloji Post-doc (doktora sonrası eğitim)	
Diğer Post-doc (______)	

18) Şu anki klinik pratiğinizi ne olarak sürdürüyorsunuz? (Uygunsa, birden çok işaretleme yapabilirsiniz.)

□ Yetişkin psikiyatrı
□ Çocuk ve Ergen psikiyatrı
□ Nöropsikiyatr
□ Yetişkin psikiyatrisi asistanı
□ Çocuk ve Ergen psikiyatrisi Asistanı
□ Pratisyen hekim
□ Başka bir uzmanlık derecesine sahip hekim (lütfen belirtiniz)
□ Psikolog (4 yıllık Psikoloji lisans mezunu)
□ Uzman Klinik Psikolog (en az 2 yıllık YL mezunu)
□ Uzman Nöropsikolog (en az 2 yıllık YL mezunu)
□ Uzman Sağlık Psikoloğu (en az 2 yıllık YL mezunu)
□ Psikolojik Danışman (4 yıllık lisans mezunu)
□ Uzman Psikolojik Danışman (en az 2 yıllık YL mezunu)
□ Sosyal Hizmet Çalışanı (4 yıllık lisans mezunu)
□ Uzman Sosyal Hizmet Çalışanı (en az 2 yıllık YL mezunu)
□ Pedagog (4 yıllık lisans mezunu)
□ Uzman Pedagog (en az 2 yıllık YL mezunu)
□ Okul öncesi öğretmeni (4 yıllık lisans mezunu)
□ Uzman okul öncesi öğretmeni (en az 2 yıllık YL mezunu)
□ Psikanalist
□ Psikanalist adayı
□ Psikoterapist
□ Psikiyatri hemşiresi (En az 2 yıllık YL mezunu)
□ Diğer (lütfen belirtiniz) _____________

19) Ruh sağlığı alanında çalışmaya başlamadan önce başka bir mesleğiniz var mıydı?

□ Hayır

□ Evet (lütfen belirtiniz) ______________________

20) Şu anda aktif klinik pratiğinizi nasıl bir ortamda sürdürüyorsunuz? (Uygunsa, birden çok işaretleme yapabilirsiniz.)

	Yarı zamanlı	**Tam zamanlı**
Devlet Tıp Fakültesi Psikiyatri Bölümü		
Devlet Tıp Fakültesi Psikiyatri-dışı bir bölüm		
Özel Tıp Fakültesi Psikiyatri Bölümü		
Özel Tıp Fakültesi Psikiyatri-dışı bir bölüm		
Devlet Ruh Hastalıkları Hastanesi		
Özel Ruh Hastalıkları Hastanesi		
Devlet Hastanesi		
Özel Hastane		
Devlet Sağlık Ocağı/Dispanser		
Özel Tıp Merkezi/Poliklinik		
Belediye Sağlık Merkezi		
Anne - Çocuk Sağlığı/ Aile Planlama Merkezleri		
Özel Psikoterapi Merkezi		
Özel Psikolojik Danışmanlık Merkezi		
Özel Eğitim ve Rehabilitasyon Merkezi		
Devlet okul-öncesi çocuk yuvası		
Devlet ilköğretim okulu		
Devlet orta öğretim okulu (lise)		
Devlet Üniversitesi		
Özel okul-öncesi çocuk yuvası		
Özel ilköğretim okulu		
Özel ortaöğretim okulu (lise)		
Özel/Vakıf Üniversitesi		
Dershane		
Cezaevi		
Adli Tıp Kurumları		
Mahkemeler		
Huzurevleri		
Kadın Sığınma Evi		
Sivil Toplum Kuruluşları (dernek, vakıf vb.)		
Rehberlik Araştırma Merkezleri		
Diğer devlet kurumları		

Diğer özel sektör kuruluşları (şirket vb.)		
Özel muayenehane		

21) Üniversitelerde öğretim üyesi olarak çalışıyor musunuz?
□ Hayır
□ Yarı zamanlı olarak çalışıyorum.
□ Tam zamanlı olarak çalışıyorum.

22) Nasıl bir üniversitede çalışıyorsunuz?
□ Devlet
□ Özel/Vakıf
□ Çalışmıyorum.

23) Alanda üniversite dışında eğitim veriyor musunuz?
□ Evet □ Hayır

24) Klinik süpervizyon veriyor musunuz?
□ Evet, ortalama HAFTADA kaç saat (lütfen belirtiniz): ________
□ Hayır

25) Kaç yıllık aktif klinik deneyiminiz var? (Psikolojik sorunlara yönelik danışmanlık, psikoterapi ve/veya ilaç tedavisi gibi hizmetleri kaç yıldır veriyorsunuz? Eğitiminiz sırasında aktif klinik faaliyette bulunduysanız onları da ekleyiniz.

____

26) Akademik unvanınız nedir?

□ Yok
□ Profesör
□ Doçent
□ Yardımcı Doçent
□ Doktor
□ Öğretim Görevlisi

27) Şu anki aktif klinik faaliyetiniz, yaklaşık yüzdelik oranlar üzerinden aşağıdaki hizmet türlerine göre nasıl dağılmaktadır? (Toplamda % 100 olması gerekmektedir. Size uygun olmayan kategoriler için de "0" girmeniz gerekmektedir).

Klinik Faaliyet Türü	**%**
İlaç tedavisi (psikofarmakoloji)	
Diğer biyolojik tedaviler (EKT gibi)	
Psikoterapi	
Psikolojik danışmanlık	
Özel eğitim	
Psiko-eğitim	
Diğer (________________)	
Toplam	**100**

28) Hastalarınızın/danışanlarınızın yaklaşık % kaçını başka uzmanlara aşağıdaki klinik müdahaleler için yönlendiriyorsunuz?

Klinik müdahale türü	%
Psikiyatrik değerlendirme/ilaç tedavisi	
Bireysel psikoterapi	
Çift psikoterapisi	
Aile psikoterapisi	
Grup psikoterapisi	
Psikolojik testler	
Psikolojik danışmanlık	
Özel eğitim	
Psiko-eğitim	
Diğer (__________)	
Toplam	**100**

29) Şu anda klinik süpervizyon alıyor musunuz? Alıyorsanız, lütfen AYDA ortalama kaç saat aldığınızı belirtiniz.

□ Hayır

□ Bireysel süpervizyon, AYDA ortalama kaç saat: ___________________

□ Grup süpervizyon, AYDA ortalama kaç saat: _____________________

□ Akran süpervizyonu, AYDA ortalama kaç saat: ____________________

30) Mesleğe başladığınızdan bugüne kadar kaç değişik süpervizörden DÜZENLİ (en az 3 ay ve haftada 1) klinik süpervizyon aldınız?

____

31) Mesleğe başladığınızdan bugüne kadar yaklaşık olarak toplam kaç saat klinik süpervizyon aldınız?

____

32) Devam ettiğiniz okullarda ve okul-dışı eğitimlerde aldığınız bütün teorik eğitimleri düşünerek, aşağıdaki her bir başlık için yaklaşık kaç SAAT teorik aldığınızı lütfen belirtiniz. (Size uygun olmayan kategoriler için "0" girmeniz gerekmektedir).

Teorik Eğitim	**Saat**
Klinik görüşme teknikleri	
Psikofarmakoloji	
Biyolojik psikiyatri	
Tanısal değerlendirme	
Psikanaliz/psikanalitik terapi	
Humanistik terapi	
Davranışçı terapi	
Bilişsel terapi	

Bilişsel-davranışçı terapi	
Sistemik terapi	
Yaratıcı sanat terapisi	
Somatik (beden yönelimli) terapi	
Transaksiyonel analiz	
Bütünleşik (integrative) terapi	
Psikolojik değerlendirme (testler)	
EMDR	
Diğer (___________)	

33) Kendi terapinizden geçtiniz mi?

□ Evet

□ Hayır

□ Devam ediyor

34) Bugüne kadar kaç farklı terapistten terapi aldınız? _______________

35) En uzun terapinizi düşünerek, toplamda kaç seans gittiğinizi lütfen belirtiniz. (Kendi terapinizden geçmediyseniz "0" yazınız.)

____

36) En uzun terapinizi düşünerek, toplamda/şu ana kadar kaç ay gittiğinizi lütfen belirtiniz. (Kendi terapinizden geçmediyseniz "0" yazınız.)

____

37) En uzun terapinizi düşünerek, ortalama AYDA kaç seans gittiğinizi lütfen belirtiniz. (Kendi terapinizden geçmediyseniz "0" yazınız.)

____

38) En uzun terapinizi düşünerek, terapistinizin teorik yönelimi nedir? (Uygunsa, birden çok işaretleme yapabilirsiniz.)

□ Kendi terapimden geçmedim.
□ Psikanaliz
□ Psikanalitik/Psikodinamik
□ Hümanistik
□ Davranışçı
□ Bilişsel
□ Bilişsel-Davranışçı
□ Sistemik Terapi
□ Somatik (beden yönelimli) terapi
□ Transaksiyonel analiz
□ EMDR
□ Eklektik
□ Bütünleşik (Integrative)
□Diğer (Lütfen belirtiniz_________)

39) Çalıştığınız yaş gruplarını lütfen işaretleyiniz. (Uygunsa, birden çok işaretleme yapabilirsiniz).
□ 0-6
□ 7-12
□ 13-18
□ 19-24
□ 25-65
□ 65 ve üstü

40) Çalıştığınız modaliteleri lütfen belirtiniz. (Uygunsa, birden çok işaretleme yapabilirsiniz).
□ Bireysel
□ Grup
□ Aile

41) Şimdiye kadar kaç adet ULUSAL bilimsel kongre/sempozyum tarzı toplantıya İZLEYİCİ olarak katıldınız? (Tam sayısını hatırlayamıyorsanız lütfen yaklaşık bir sayı giriniz.)

____

42) Şimdiye kadar kaç adet ULUSAL bilimsel kongre/sempozyum tarzı toplantıda sunum yaptınız? (Tam sayısını hatırlayamıyorsanız lütfen yaklaşık bir sayı giriniz.)

____

43) Şimdiye kadar kaç adet ULUSLARARASI bilimsel kongre/sempozyum tarzı toplantıya İZLEYİCİ olarak katıldınız? (Tam sayısını hatırlayamıyorsanız lütfen yaklaşık bir sayı giriniz.)

____

44) Şimdiye kadar kaç adet ULUSLARARASI bilimsel kongre/sempozyum tarzı toplantıda sunum yaptınız? (Tam olarak sayısını hatırlayamıyorsanız lütfen yaklaşık bir sayı giriniz.)

____

45) ULUSAL Yayınlarda bilimsel/mesleki yayınlarınızın olduğu grubu ve o işaretlediğiniz grupta kaç adet çalışmanızın olduğunu lütfen belirtiniz.

□ Yok

□ Hakemsiz dergi makalesi

□ Hakemli dergi makalesi

□ Kitap bölümü

□ Kitap

46) ULUSLARARASI Yayınlarda bilimsel/mesleki yayınlarınızın olduğu grubu ve o işaretlediğiniz grupta kaç adet çalışmanızın olduğunu lütfen belirtiniz.

□ Yok

□ Hakemsiz dergi makalesi

□ Hakemli dergi makalesi

□ Kitap bölümü

□ Kitap

47) Bir AYDA ortalama kaç bilimsel/mesleki makale okuma imkanınız oluyor?

____

48) Bir AYDA ortalama kaç bilimsel/mesleki kitap okuma imkanınız oluyor?

____

49) Şu anda araştırmacı olarak kaç bilimsel çalışmaya dahilsiniz?

____

50) Aşağıdaki dillerden İYİ veya ÇOK İYİ derecede bildiklerinizi OKUMA, YAZMA, KONUŞMA ve KLİNİK FAALİYET YÜRÜTEBİLME boyutlarında belirtilen kolonlarda (X) ile işaretleyiniz.

	Okuma	**Yazma**	**Konuşma**	**Klinik Faaliyet Yürütebilme**
Almanca				
Arapça				
Arnavutça				
Azeri				
Bulgarca				
Boşnakça				
Çerkez				
Ermenice				
Farsça				
Fransızca				
Gürcüce				
İbranice				
İngilizce				
İspanyolca				
İtalyanca				
Kürtçe				
Ladino				
Lazca				
Rumca				
Rusça				
Diğer 1: ________				
Diğer 2: ________				

51) İzlenimlerinize göre size gelen danışanların/hastaların yaklaşık yüzdelerini aşağıdaki kategorilere göre yazabilir misiniz? (Toplamda % 100 olmasına lütfen dikkat ediniz. Size uygun olmayan kategoriler için "0" girmeniz gerekmektedir).

	%
İlk değerlendirme seanslarından sonra (ya da sırasında) kendi istekleriyle size gelmeye devam etmeyenler	
İlk değerlendirme seanslarında sizin başka bir klinisyene gönderdikleriniz	
İlk değerlendirmeden sonra size düzenli gelmeye başladığı halde verdiğiniz klinik hizmeti yarıda bırakıp ayrılanlar	
Size düzenli gelip verdiğiniz klinik hizmeti uygun bulduğunuz süre içinde tamamlayanlar	
Toplam	**100**

52) Sizden klinik hizmet almaya başlayıp yarıda bırakanların % kaçının aşağıdaki sebeplerden dolayı bıraktıklarını lütfen belirtiniz. (Toplamda hepsinin % 100 olmasına lütfen dikkat ediniz. Size uygun olmayan kategoriler için "0" girmeniz gerekmektedir).

	%
Ekonomik nedenlerle	
Klinik müdahaleye hazır olmadıkları için	
İlişkide oldukları diğer kişilerin engellemeleri nedeniyle	
Ulaşım/yer değiştirme gibi faktörler nedeniyle	
Klinik ilişkideki ağırlıkla sizden kaynaklanan zorluklar nedeniyle	
Klinik ilişkideki ağırlıkla çalıştığınız yerden/kurumdan kaynaklanan zorluklar nedeniyle	
Klinik/teorik yöneliminizin danışanın/hastanın sorunlarına/ihtiyaçlarına hitap etmemesi nedeniyle	
Diğer nedenlerle (_________)	
Toplam	**100**

53) Size düzenli gelip verdiğiniz klinik hizmeti uygun bulduğunuz süre içinde tamamlayanlar arasından % kaçının aşağıdakilerden dolayı tamamladıklarını belirtiniz. (Toplamda % 100 olması ve size uygun olmayan kategoriler için "0" girmeniz gerekmektedir).

	%
İlk başlangıç zamanlarına göre % 75-100 oranında (oldukça yüksek derecede) iyileşme gösterdiği	
İlk başlangıç zamanlarına göre % 50-74 oranında (yüksek derecede) iyileşme gösterdiği	
İlk başlangıç zamanlarına göre % 25-49 oranında (orta derecede) iyileşme gösterdiği	
İlk başlangıç zamanlarına göre % 5-24 oranında (az derecede) iyileşme gösterdiği	
İlk başlangıç zamanlarına göre durumlarında pek bir değişiklik olmadığı	
İlk başlangıç zamanlarına göre durumlarının daha da kötüye gittiği	
Toplam	**100**

54) Size klinik hizmet almak için başvuran danışanların/hastaların yaklaşık % kaçı daha önce başka bir klinisyene gitmiş oluyorlar? (Size uygun olmayan kategoriler için "0" girmeniz gerekmektedir).

____

55) Sizden önce başka bir klinisyene gitmiş olanların % kaçınının aşağıdakilere göre bu deneyimlerinden ne kadar memnun olduklarını lütfen belirtiniz. (Toplamda % 100 olması ve size uygun olmayan kategoriler için "O" girmeniz gerekmektedir).

	%
Önceki klinik deneyimlerinden bir miktar memnun	
Önceki klinik deneyimleri konusunda belirsiz/ortada	
Önceki klinik deneyimlerinden bir miktar memnuniyetsiz	
Önceki klinik deneyimlerinden çok memnuniyetsiz	
Toplam	100

56) Sizce Türkiye'de psikolojik sorun/zorluk yaşayan insanların % kaçı için bunları çözmede aşağıdaki etkinliklerin BİRİNCİL derecede faydalı olacağını düşünürsünüz? (Toplamda % 100 olması ve size uygun olmayan kategoriler için "0" girmeniz gerekmektedir.)

	%
Ruh sağlığı profesyonelinden yardım alması	
Hobi	
Arkadaş desteği	
Aile desteği	
İşyeri desteği	
Dini/manevi destek	
Ekonomik düzelme	
Okuma/bilgilenme/eğitim	
Toplam	100

57) Sizce Türkiye'de profesyonel ruh sağlığı hizmeti alması gerekenlerin % kaçı için aşağıdaki klinik müdahaleler BİRİNCİL derecede tercih edilmelidir? (Toplamda hepsinin % 100 olması ve size uygun olmayan kategoriler için "0" girmeniz gerekmektedir.)

	%
İlaç tedavisi (Psikofarmakoloji)	
Diğer biyolojik tedaviler (EKT gibi)	
Psikoterapi	
Psikolojik danışmanlık	
Özel eğitim	
Psiko-eğitim	
Diğer (Lütfen belirtiniz)	
Toplam	100

58) Sizce Türkiye'de profesyonel ruh sağlığı hizmeti alması gerekenlerin % kaçı için aşağıdaki klinik müdahaleler İKİNCİL derecede tercih edilmelidir?(Toplamda hepsinin % 100 olması ve size uygun olmayan kategoriler için "0" girmeniz gerekmektedir).

	%
İlaç tedavisi (Psikofarmakoloji)	
Diğer biyolojik tedaviler (EKT gibi)	
Psikoterapi	
Psikolojik danışmanlık	
Özel eğitim	
Psiko-eğitim	
Diğer (Lütfen belirtiniz)	
Toplam	100

59) Psikoterapiden faydalanacağını düşündüğünüz danışanların/hastaların yaklaşık % kaçı için aşağıdaki psikoterapi türleri BİRİNCİL tercih olmalıdır? (Tercihlerinizin toplamda % 100 olması ve size uygun olmayan kategoriler için "0" girmeniz gerekmektedir).

	%
Psikanaliz	
Psikanalitik/Psikodinamik	
Humanistik	
Davranışçı	
Bilişsel	
Bilişsel-Davranışçı	
Sistemik terapi	
Yaratıcı Sanat Terapisi	
Somatik (Beden Yönelimli) terapi	
Transaksiyonel analiz (Berne)	
EMDR	
Eklektik	
Bütünleşik (Integrative)	
Diğer (Lütfen belirtiniz:______________________________)	
Toplam	**100**

60) Aşağıdaki yaklaşımlardan hangileri kendi teorik/klinik yöneliminizi yaklaşık ne oranda (%) şekillendirmektedir? (İşaretlediklerinizin toplamda % 100 olmasına lütfen dikkat ediniz. Size uygun olmayan kategoriler için "0" girmeniz gerekmektedir).

	%
Biyolojik psikiyatri	
Klasik/Freudçu psikanaliz	
Klasik nesne ilişkileri ekolü (M. Klein)	
Bağımsız nesne ilişkileri ekolü (Fairbairn, Winnicott, vb.)	
Ego psikolojisi (Anna Freud, Hartmann, vb.)	
Kişilerarası psikanaliz (Sullivan)	
Çağdaş Fransız Psikanalizi	
Lacancı psikanaliz	
Kendilik psikolojisi (Kohut)	
Öznelliklerarası psikanaliz (Stolorow, vb.)	
Bağlanma Kuramı	

İlişkisel psikanaliz (Mitchell, Aron, vb.)	
Diğer psikanalitik ekoller (Lütfen belirtiniz) _________________	
Varoluşçu psikoterapi (Rollo May, vb.)	
Geştalt psikoterapi (Perls, vb.)	
Danışan-merkezli psikoterapi (Rogers, vb.)	
Diğer humanistik ekoller (Lütfen belirtiniz)_______________	
Davranışçı terapi (Skinner, Lindsley, Solomon, Wolpe, Eysenck, vb.)	
Bilişsel terapi (Beck, Ellis, vb.)	
Bilişsel-Davranışçı terapi (Clark, Barlow, Lazarus, vb.)	
Sistemik terapi	
Yaratıcı Sanat terapisi	
Somatik (Beden yönelimli)	
Transaksiyonel analiz (Berne)	
EMDR	
Eklektik	
Bütünleşik (Integrative)	
Diğer (lütfen belirtiniz) ___________________________________	
Toplam	**100**

61) Şu ana kadar alanda gördüğünüz toplam vaka sayısı kaçtır? (Tam sayısını hatırlayamıyorsanız lütfen yaklaşık bir sayı giriniz.)

____

62) Aşağıda klinik ortamda karşılaşılabilecek bazı durumlar belirtilmiştir. Bu durumlarla klinik ortamda karşılaştığınızda ne derece kolay/zor çalışabileceğinizi aşağıda verilen ölçeğe göre lütfen değerlendiriniz.

1= Pek zorlanmadan çalışabilirim
2= Biraz zorlanarak çalışabilirim
3= Zorlanarak da olsa çalışabilirim
4= Çok fazla zorlanacağım için çalışmayı tercih etmem
5= Çalışamam

Lütfen her bir durumda ne kadar kolay/zor çalışabileceğinizi yukarıdaki ölçeğe göre değerlendirip, uygun kutuyu yuvarlak içine alınız.

Alkol/madde bağımlılığı	1	2	3	4	5
Anti-sosyal kişiliği ön planda olanlar	1	2	3	4	5
Ciddi intihar riski taşıyanlar	1	2	3	4	5
Cinsel taciz mağduru çocuklar	1	2	3	4	5
Cinsel taciz mağduru kadınlar	1	2	3	4	5
Dini inançları sizden farklı olanlar	1	2	3	4	5
Eğitimsiz ya da az eğitimli olanlar	1	2	3	4	5
Eşcinseller	1	2	3	4	5
Etnik kimliği sizden farklı olanlar	1	2	3	4	5
Fiziksel ve psikolojik şiddet mağduru çocuklar	1	2	3	4	5

Fiziksel ve psikolojik şiddet mağduru yetişkinler	1	2	3	4	5
Fiziksel ve psikolojik şiddet uygulayanlar	1	2	3	4	5
İleri yaş grubunda olan kişiler	1	2	3	4	5
Narsisistik kişilik örgütlenmesi ön planda olanlar	1	2	3	4	5
Politik şiddet/işkence mağdurları	1	2	3	4	5
Seyri kötü kanser hastaları	1	2	3	4	5
Sınır kişilik örgütlenmesi ön planda olanlar	1	2	3	4	5
Şizofreni hastaları	1	2	3	4	5
Tacizci/tecavüzcüler	1	2	3	4	5
Yoksullar	1	2	3	4	5

63) Verdiğiniz ruh sağlığı hizmetleri çerçevesinde aşağıdaki boyutlardaki memnuniyet derecenizi belirtilen ölçeğe göre lütfen değerlendiriniz.
1= Hiç memnun değilim 2= Biraz memnunum 3= Memnunum 4= Çok memnunum.

	1	2	3	4
Mesleki tatmin	1	2	3	4
Ekonomik gelir düzeyi	1	2	3	4
Sosyal statü	1	2	3	4
Sosyal güvence	1	2	3	4
Çalışma ortamı	1	2	3	4
Meslek örgütü	1	2	3	4

Değişik terapi ekolleri tarafından psikoterapide KALICI terapötik dönüşüm sağlamada önemli olduğu ileri sürülen aşağıdaki faktörlerin her birinin sizce ne kadar önemli olduğunu işaretleyiniz.
0= Hiç önemli değil
1= Biraz önemli
2= Orta derecede önemli
3= Oldukça önemli
4= Çok önemli

64) Danışanda gelişenlere dair faktörler					
Katarsis/Abreaksiyon	0	1	2	3	4
İçgörü (duygulanımsal)	0	1	2	3	4
İçgörü (bilişsel)	0	1	2	3	4
Düzeltici duygusal yaşantı	0	1	2	3	4
Örtük (implicit) ilişkisel öğrenme	0	1	2	3	4
Terapi ilişkisinin içselleştirilmesi	0	1	2	3	4
Zihinselleştirme (mentalization)	0	1	2	3	4
Duygusal farkındalık	0	1	2	3	4
Bilişsel farkındalık	0	1	2	3	4
Bedensel farkındalık	0	1	2	3	4

Davranışsal öğrenme	0	1	2	3	4
65) Terapi tekniklerine dair faktörler					
Serbest çağrışımların yorumlanması	0	1	2	3	4
Aktarımın yorumlanması	0	1	2	3	4
Dirençlerin yorumlanması	0	1	2	3	4
Rüyaların yorumlanması	0	1	2	3	4
Empati	0	1	2	3	4
Bilişsel yeniden yapılandırma	0	1	2	3	4
Sakınılan şeylere maruz bırakma (exposure)	0	1	2	3	4
Telkin	0	1	2	3	4
Tavsiye/Öneri	0	1	2	3	4
Yüzleştirme (Confrontation)	0	1	2	3	4
İmgeleme (Imagining)	0	1	2	3	4
66) Terapiste dair faktörler					
Terapistin nesnelliği	0	1	2	3	4
Terapistin yansızlığı (neutrality)	0	1	2	3	4
Terapistin esnekliği	0	1	2	3	4
Terapi çerçevesinin tutarlılığı/sürekliliği	0	1	2	3	4
Karşı-aktarımın terapötik kullanımı	0	1	2	3	4
Terapistin danışanı koşulsuz kabulü	0	1	2	3	4
Terapistin içtenliği	0	1	2	3	4
Terapistin kişiliği/tarzı	0	1	2	3	4
Terapistin kendi terapisinden geçmiş olması	0	1	2	3	4
67) İlişkiye dair faktörler					
Terapist-danışan ilişkisinin terapötik kalitesi	0	1	2	3	4

Modül 4: Sosyal Kimlik

Bu bölümde, aşağıda sıralanan kimliklerin sizi ne kadar tanımladığı ya da bu kimliklere kendinizi ne kadar bağlı hissettiğinizi merak ediyoruz. Lütfen her bir kimlik için, sizi ne kadar tanımladığını düşünerek, aşağıdaki ölçeğe göre değerlendiriniz.

0= Bu kimlik beni **HİÇ** tanımlamıyor
1= Bu kimlik beni **BİRAZ** tanımlıyor
2= Bu kimlik beni **ORTA DERECEDE** tanımlıyor
3= Bu kimlik beni **OLDUKÇA İYİ** tanımlıyor
4= Bu kimlik beni **ÇOK UYGUN** biçimde tanımlıyor

68) Lütfen aşağıdaki kimlikleri yukarıda					
Dünyalı	0	1	2	3	4
Asyalı	0	1	2	3	4
Avrupalı	0	1	2	3	4

Ortadoğulu	0	1	2	3	4
Türkiyeli	0	1	2	3	4
Türk	0	1	2	3	4
Kürt	0	1	2	3	4
Arap	0	1	2	3	4
Çerkez	0	1	2	3	4
Boşnak	0	1	2	3	4
Laz	0	1	2	3	4
Pomak	0	1	2	3	4
Gürcü	0	1	2	3	4
Arnavut	0	1	2	3	4
Ermeni	0	1	2	3	4
Roman (Çingene)	0	1	2	3	4
Musevi/Yahudi	0	1	2	3	4
Rum	0	1	2	3	4
Süryani	0	1	2	3	4
Müslüman	0	1	2	3	4
Sünni	0	1	2	3	4
Alevi	0	1	2	3	4
Şii	0	1	2	3	4
Şafi	0	1	2	3	4
Hıristiyan	0	1	2	3	4
Ortodoks	0	1	2	3	4
Katolik	0	1	2	3	4
Protestan	0	1	2	3	4
Budist	0	1	2	3	4
Dinsiz/Ateist/Agno	0	1	2	3	4
Doğup	0	1	2	3	4
Halen yaşadığınız	0	1	2	3	4
Sağcı	0	1	2	3	4
Solcu	0	1	2	3	4
Merkezci	0	1	2	3	4
Milliyetçi	0	1	2	3	4
Muhafazakar	0	1	2	3	4
İslamcı	0	1	2	3	4
Faşist	0	1	2	3	4
Komünist	0	1	2	3	4
Sosyalist	0	1	2	3	4
Devrimci	0	1	2	3	4

Liberal	0	1	2	3	4
Sosyal Demokrat	0	1	2	3	4
Demokrat	0	1	2	3	4
Kemalist	0	1	2	3	4
Atatürkçü	0	1	2	3	4
Anadolulu	0	1	2	3	4
Trakyalı	0	1	2	3	4
Heteroseksüel	0	1	2	3	4
Eşcinsel	0	1	2	3	4
Biseksüel	0	1	2	3	4

Modül 5: Klinik Bilgiler

69) Aşağıda zaman zaman herkeste olabilecek yakınma ve sorunların bir listesi vardır. Lütfen her birinin **son bir ay içinde** sizi ne ölçüde rahatsız ve tedirgin ettiğini gösteren seçeneği yuvarlak içine alınız.

O=HİÇ
1=ÇOK AZ
2=ORTA DERECEDE
3=OLDUKÇA FAZLA
4= İLERİ DERECEDE

İçinizdeki sinirlilik ve titreme hali	0	1	2	3	4
Baygınlık, baş dönmesi	0	1	2	3	4
Bir başka kişinin düşüncelerinizi kontrol edeceği fikri	0	1	2	3	4
Başınıza gelen sıkıntılardan dolayı başkalarının suçlu olduğu duygusu	0	1	2	3	4
Olayları hatırlamada güçlük	0	1	2	3	4
Çok kolay kızıp öfkelenme	0	1	2	3	4
Göğüs (kalp) bölgesinde ağrılar	0	1	2	3	4
Meydanlık (açık) yerlerden korkma duygusu	0	1	2	3	4
Yaşamınıza son verme düşüncesi	0	1	2	3	4
İnsanların çoğuna güvenilmeyeceği hissi	0	1	2	3	4
İştahta bozukluklar	0	1	2	3	4
Hiçbir nedeni olmayan ani korkular	0	1	2	3	4
Kontrol edemediğiniz duygu patlamaları	0	1	2	3	4
Başka insanlarla beraberken bile yalnızlık hissetme	0	1	2	3	4
İşleri bitirme konusunda kendini engellenmiş hissetme	0	1	2	3	4
Yalnızlık hissetme	0	1	2	3	4
Hüzünlü, kederli hissetme	0	1	2	3	4

Hiçbir şeye ilgi duymamak	0	1	2	3	4
Kendini ağlamaklı hissetme	0	1	2	3	4
Kolayca incinebilme, kırılma	0	1	2	3	4
İnsanların sizi sevmediğine, size kötü davrandığına inanma	0	1	2	3	4
Kendini diğer insanlardan daha aşağı görme	0	1	2	3	4
Mide bozukluğu, bulantı	0	1	2	3	4
Diğer insanların sizi gözlediği ya da hakkınızda konuştuğu duygusu	0	1	2	3	4
Uykuya dalmada güçlük	0	1	2	3	4
Yaptığınız şeyleri tekrar tekrar doğru mu diye kontrol etmek	0	1	2	3	4
Karar vermede güçlükler	0	1	2	3	4
Otobüs, tren, metro gibi umumi vasıtalarla seyahatlerden korkma	0	1	2	3	4
Nefes darlığı, nefessiz kalma	0	1	2	3	4
Sıcak, soğuk basmaları	0	1	2	3	4
Sizi korkuttuğu için bazı eşya, yer ya da etkinliklerden uzak kalmaya çalışmak.	0	1	2	3	4
Kafanızın bomboş kalması	0	1	2	3	4
Bedeninizin bazı bölgelerinde uyuşmalar, karıncalanmalar	0	1	2	3	4
Hatalarınız için cezalandırılmanız gerektiği düşüncesi	0	1	2	3	4
Gelecekle ilgili umutsuzluk duyguları	0	1	2	3	4
Dikkati bir şey üzerine toplamada güçlük	0	1	2	3	4
Bedenin bazı bölgelerinde zayıflık, güçsüzlük hissi	0	1	2	3	4
Kendini gergin ve tedirgin hissetme	0	1	2	3	4
Ölme ve ölüm üzerine düşünceler	0	1	2	3	4
Birini dövme, ona zarar verme, yaralama isteği	0	1	2	3	4
Birşeyleri kırma, dökme isteği	0	1	2	3	4
Diğer insanların yanında iken yanlış bir şey yapmamaya çalışmak	0	1	2	3	4
Kalabalıklardan rahatsızlık duymak	0	1	2	3	4
Başka insanlara hiç yakınlık duymamak	0	1	2	3	4
Dehşet ve panik nöbetleri	0	1	2	3	4
Sık sık tartışmaya girmek	0	1	2	3	4
Yalnız kalındığında sinirlilik hissetme	0	1	2	3	4
Başarılarınıza rağmen diğer insanlardan yeterince takdir	0	1	2	3	4

görmemek					
Kendini yerinde duramayacak kadar tedirgin hissetmek	0	1	2	3	4
Kendini değersiz görme duygusu	0	1	2	3	4
Eğer izin verirseniz insanların sizi sömüreceği duygusu	0	1	2	3	4
Suçluluk duyguları	0	1	2	3	4
Aklınızda bir bozukluk olduğu fikri	0	1	2	3	4

70) Aşağıda yakın duygusal ilişkilerinizde kendinizi nasıl hissettiğinize ilişkin çeşitli ifadeler yer almaktadır. Yakın duygusal ilişkilerden kastedilen arkadaşlık, dostluk, romantik ilişkiler ve benzerleridir.
Lütfen her bir ifadeyi bu tür ilişkilerinizi düşünerek okuyun ve her bir ifadenin sizi ne ölçüde tanımladığını aşağıdaki 7 aralıklı ölçek üzerinde değerlendirip uygun kutuyu yuvarlak içine alınız.

1-------------2-------------3-------------4-------------5-------------6-------------7

Beni hiç tanımlamıyor — Beni kısmen tanımlıyor — Tamamıyla beni tanımlıyor

Başkalarına kolaylıkla güvenemem.	1	2	3	4	5	6	7
Kendimi bağımsız hissetmem benim için çok önemli.	1	2	3	4	5	6	7
Başkalarıyla kolaylıkla duygusal yakınlık kurarım.	1	2	3	4	5	6	7
Bir başka kişiyle tam anlamıyla kaynaşıp bütünleşmek isterim.	1	2	3	4	5	6	7
Başkalarıyla çok yakınlaşırsam incitileceğimden korkuyorum.	1	2	3	4	5	6	7
Başkalarıyla yakın duygusal ilişkilerim olmadığı sürece oldukça rahatım.	1	2	3	4	5	6	7
İhtiyacım olduğunda yardıma koşacakları konusunda başkalarına her zaman güvenebileceğimden emin değilim.	1	2	3	4	5	6	7
Başkalarıyla tam anlamıyla duygusal yakınlık kurmak istiyorum.	1	2	3	4	5	6	7
Yalnız kalmaktan korkarım.	1	2	3	4	5	6	7
Başkalarına rahatlıkla güvenip bağlanabilirim.	1	2	3	4	5	6	7
Çoğu zaman, romantik ilişkide olduğum insanların beni gerçekten sevmediği konusunda endişelenirim.	1	2	3	4	5	6	7
Başkalarına tamamıyla güvenmekte zorlanırım.	1	2	3	4	5	6	7
Başkalarının bana çok yakınlaşması beni endişelendirir.	1	2	3	4	5	6	7
Duygusal yönden yakın ilişkilerim olsun isterim.	1	2	3	4	5	6	7
Başkalarının bana dayanıp bel bağlaması konusunda oldukça rahatımdır.	1	2	3	4	5	6	7
Başkalarının bana, benim onlara verdiğim kadar değer vermediğinden kaygılanırım.	1	2	3	4	5	6	7
İhtiyacınız olduğunda hiç kimseyi yanınızda bulamazsınız.	1	2	3	4	5	6	7
Başkalarıyla tam olarak kaynaşıp bütünleşme arzum bazen	1	2	3	4	5	6	7

onları ürkütüp benden uzaklaştırıyor							
Kendi kendime yettiğimi hissetmem benim için çok önemli.	1	2	3	4	5	6	7
Birisi bana çok fazla yakınlaştığında rahatsızlık duyarım.	1	2	3	4	5	6	7
Romantik ilişkide olduğum insanların benimle kalmak istemeyeceklerinden korkarım.	1	2	3	4	5	6	7
Başkalarının bana bağlanmamalarını tercih ederim.	1	2	3	4	5	6	7
Terk edilmekten korkarım	1	2	3	4	5	6	7
Başkalarıyla yakın olmak beni rahatsız eder.	1	2	3	4	5	6	7
Başkalarının bana, benim istediğim kadar yakınlaşmakta gönülsüz olduklarını düşünüyorum.	1	2	3	4	5	6	7
Başkalarına bağlanmamayı tercih ederim.	1	2	3	4	5	6	7
İhtiyacım olduğunda insanları yanımda bulacağımı biliyorum.	1	2	3	4	5	6	7
Başkaları beni kabul etmeyecek diye korkarım	1	2	3	4	5	6	7
Romantik ilişkide olduğum insanlar, genellikle onlarla, benim kendimi rahat hissettiğimden daha yakın olmamı isterler.	1	2	3	4	5	6	7
Başkalarıyla yakınlaşmayı nispeten kolay bulurum.	1	2	3	4	5	6	7

71) Aşağıda iş ile ilgili tutumları yansıtan maddeler yer almaktadır. Lütfen her bir maddede belirtilen
durumu ne kadar sıklıkla yaşadığınızı uygun kutuya (X) işareti koyarak belirtiniz. Size verilen bazı cümlelelerde **"işim gereği karşılaştığım insanlar"** ifadesi yer almaktadır. Siz de, bu ifade ile karşılaştığınızda, kendi işiniz dolayısıyla hizmet verdiğiniz, sorunlarıyla uğraştığınız ya da işi yürütmek için muhatap olduğunuz kişileri düşününüz.
Bu soruları mümkün olabildiğince samimi bir şekilde cevaplamaya çalışın.

	Hiçbir zaman	Çok nadir	Bazen	Çoğu zaman	Her zaman
İşimden soğuduğumu hissediyorum.					
İş dönüşü kendimi ruhen tükenmiş hissediyorum.					
Sabah kalktığımda bir gün daha bu işi kaldıramayacağımı hissediyorum .					
İşim gereği karşılaştığım insanların ne hissettiğini hemen anlarım.					
İşim gereği karşılaştığım bazı kimselere sanki insan değillermiş gibi davrandığımı fark ediyorum.					
Bütün gün insanlarla uğraşmak benim için gerçekten çok yıpratıcı.					
İşim gereği karşılaştığım insanların sorunlarına en uygun çözüm yollarını bulurum.					
Yaptığım işten tükendiğimi hissediyorum.					
Yaptığım iş sayesinde insanların yaşamına katkıda bulunduğuma inanıyorum.					

Bu işte çalışmaya başladığımdan beri insanlara karşı sertleştim.					
Bu işin beni giderek katılaştırmasından korkuyorum.					
Çok şeyler yapabilecek güçteyim.					
İşimin beni kısıtladığını hissediyorum.					
İşimde çok fazla çalıştığımı hissediyorum.					
İşim gereği karşılaştığım insanlara ne olduğu umurumda değil.					
Doğrudan doğruya insanlarla çalışmak bende çok fazla stres yaratıyor.					
İşim gereği karşılaştığım insanlarla aramda rahat bir hava yaratırım.					
İnsanlarla yakın bir çalışmadan sonra kendimi canlanmış hissediyorum.					
Bu yolda birçok kayda değer başarı elde ettim.					
Yolun sonuna geldiğimi hissediyorum.					
İşimdeki duygusal konulara soğukkanlılıkla yaklaşırım.					
İşim gereği karşılaştığım insanların bazı problemlerini sanki ben yaratmışım gibi davrandıklarını hissediyorum.					